CHILDREN, YOUTH, AND FAMILIES IN THE SOUTHEAST

HEARING

BEFORE THE

SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES HOUSE OF REPRESENTATIVES

NINETY-EIGHTH CONGRESS

FIRST SESSION

HEARING HELD IN MIAMI, FLA., ON
OCTOBER 14, 1983

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CHILDREN, YOUTH, AND FAMILIES IN THE SOUTHEAST

FRIDAY, OCTOBER 14, 1983

House of Representatives,
Select Committee on Children, Youth, and Families,
Miami, Fla.

The select committee met, pursuant to call, at 9:30 a.m., in the Board Administration Building, Miami, Fla., Hon. George Miller (chairman of the select committee) presiding.

Members present: Representatives Miller, Lehman, Boggs, and Bliley.

Staff present: Ann Rosewater, deputy staff director; Karabelle Pizzigati, professional staff; Christine Elliott-Groves, minority staff director; and Joan Godley, committee clerk.

Chairman **Miller**. The House Select Committee on Children, Youth, and Families will now convene the third regional hearing of the select committee.

Earlier this month the committee held a regional hearing in New York, and a week ago we were in St. Paul, Minn. In the coming weeks the select committee will go to Salt Lake City and to southern California to complete this year's regional hearings.

The purpose of these hearings is to gather information from individuals involved at the State and local level with children, youth, and families. We want to hear not only about the problems that they are seeing, but also hopefully learn about strategies that have been developed at the local and State levels which have been successful. We should act as a conduit for bringing the best available information to the Congress of the United States, so that those who make public policy on almost a daily basis will be fully informed about current conditions, so that we do not make mistakes or create policies that in fact are detrimental to the interests of our children and to our families.

I am delighted that the committee is represented today by Mrs. Lindy Boggs, who is the chairman of our Task Force on Crisis Intervention. Lindy, as most of you know, represents New Orleans, and has been a very, very active participant in children and families issues in the Appropriations Committee.

And also we are joined by Congressman Lehman of Miami, who was very helpful in creating this committee, who also serves on the Appropriations Committee, and is the chairman of our Task Force on Prevention Strategies. Mr. Lehman was nice enough to host a site visit yesterday for myself and the staff of the committee at the

Mailman Clinic, where I think we learned a lot about efforts being made in the Miami area with respect to prevention strategies.

We are also joined by Congressman Bliley of Virginia, who is the ranking member on the Task Force on Prevention Strategies and serves on the Energy and Commerce Committee, and is very much involved in health issues on that committee.

Members of the public can see that we have selected members from the various committees of jurisdiction in the U.S. Congress, so that the information that is developed through our hearings will provide input into the decisions that various other committees make.

I would like to now recognize Congressman Lehman, if you have an opening statement that you would like to make.

Mr. LEHMAN. Thank you, Mr. Chairman. I, really, for the sake of time, will not make an opening statement, except to thank the members of the committee for being here. Miami is a good place to look at some of the problems we are dealing with, because whatever we have not only in this country but throughout the world, I think that Miami and South Florida is a microcosm of the stresses and the strains and the problems socially, politically, and economically of the families that exist throughout the world.

I only wish Superintendent Britton had said we were going to change some school attendance balances, then I know we would have had an overflowing room today.

Chairman MILLER. Congresswoman Boggs.

Mrs. BOGGS. Thank you, Mr. Chairman. I, too, would like to thank the host committee for having us here and thank the school board for being able to cooperate with us in such a splendid fashion.

Mr. Lehman, we are very pleased with all the arrangements that you and your staff and committee staff have been able to make for us. I am especially pleased to be here and to welcome with great particularity Eva LeGard, who is with the Governor's task force on education in Louisiana, my home State, and Linda Irwin from New Orleans, who heads a wonderful organization called Youth Alternatives.

I am so pleased, too, Mr. Chairman, that we are having this meeting in the South. Southern States have particular difficulties due to rural areas, but have been so open to innovative ways of meeting the problems. I know that we will gain a great deal of insight and knowledge from the testimony that we will hear today. I thank you for holding this hearing in the South.

Chairman MILLER. Congressman Bliley.

Mr. BLILEY. Thank you, Mr. Chairman. First of all, I would like to thank all of our witnesses for taking time from their busy schedules in order to be with us today. I know that that time is valuable and I hope that by the end of the day that they will consider it time well spent.

On my own part, I would like to take this opportunity to explain why I consider these regional hearings to be so very important. They are important, first of all, because they reflect one of the primary political facts in America. That is, that the ideas which really run this country, which make it an international and historical success story, do not come from Washington. Rather, those ideas come from the people in the country who deal daily with our national problems on their own local level, in their communities, their churches, their schools, their families, and their neighborhoods.

It has been shown time and again that the best solutions to problems are found most often by the people who work most directly with the problem.

Further, it is only when those same people are committed to the ideas upon which solutions are based that those solutions will have a real chance of success. So what is the role of the Federal Government in all this? Clearly its role is not to impose solutions from above, rather it is to find out what the people in the front lines want to do to solve their problems and then to help them do it.

Many examples come to mind of groups and organizations which have come up with good workable solutions, and require only the smallest assistance to help them succeed. Parents groups are springing up all of the time and that seems to me to be a very hopeful sign. We ought to be listening to these truly grassroots organizations and hearing what they have to say about the best solutions to their problems.

One rather frightening example of the Federal Government not listening to those it attempts to help will be touched upon by one of our witnesses on the third panel, Marie Mitchell, from the teen services program at Grady Memorial Hospital in Atlanta. Apparently a random sampling showed that the information most wanted by sexually active girls 16 and under was "how to say 'no' without hurting the other person's feelings." Yet, how many federally funded planning clinics do you suppose make transmission of that kind of information a top priority in their services to teens? I certainly haven't heard of many.

In closing, I would just like to reiterate my thanks to all of the witnesses on our panels today. I am certain their testimony will be informative and I am looking forward to hearing it.

Thank you, Mr. Chairman.

Chairman MILLER. Thank you.

[Prepared statement of Congressman Lawrence Smith follows:]

PREPARED STATEMENT OF HON. LAWRENCE J. SMITH, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

MISSING CHILDREN

Mr. Chairman, earlier this week the made-for-TV movie "Adam" premiered on NBC. "Adam" is the story of an heinous crime perpetrated against an innocent 6 year old boy and his family. Adam Walsh of Hollywood, Florida, was abducted from the Hollywood Shopping Mall on July 27, 1981. After two weeks of the largest manhunt in Florida's history, Adam's remains were found 150 miles north of his home. His killer has never been apprehended.

Each year thousands of children are missing, disappearing from their homes, vanishing without a trace by abduction, assault and child molestation, and murder. Recent, infamous cases in Florida, such as the Adam Walsh case, have involved not only the kidnapping of children, but gruesome murders that have received attention in Florida and throughout the country. Adam's parents, John and Reve Walsh, have not let Adam's death become another statistic and have launched a national campaign which resulted in the passage in 1982 of the Missing Children's Act and the establishment of a national computerized file for missing children and unidentified bodies.

Floridians are familiar with cases where missing children have been found safe. But far more have disappeared without a trace. I want to draw the attention of my colleagues to this national problem. It is time to change a national law enforcement system that has been unresponsive to children. We must stress in our communities that parents need to educate their children to protect them from injury or death at the hand of an abductor. Children are vulnerable. Too many children would talk to a stranger for the offer of an ice cream cone.

It is an unfortunate fact that approximately two million children will disappear this year. Over one million children are being abused annually in the United States with 2,000 of these children being killed. An estimated 60 percent of missing children are sexually abused, physically exploited, and psychologically damaged through abduction and kidnapping.

In 1982, as chairman of the Criminal Justice Committee, I was successful in obtaining a $75,000 appropriation from the Florida State legislature to establish a state-wide computer system for missing children though the Florida Department of Law Enforcement. Florida has taken a leadership role by instituting a clearinghouse computer system that is designed to collect, store and disseminate information on missing children and act as a central depository. Today, this is the only fully operational system of its kind to trace missing children in the U.S. This unique system searches on the basis of physical description alone, without name or birthdate. Also, it provides assistance to parents as a liaison from law enforcement agencies to the public.

The FBI is in the process of creating a system comparable to Florida's clearinghouse. A five member national panel including Broward County's medical examiner, Dr. Ronald Wright, was established to help the FBI create a national unidentified dead body file. The FBI has two-thirds of this capability implemented. Mr. Chairman, having reviewed the statistics previously mentioned, I would like to see the select committee urge each state to emulate Florida's clearing house computer system. Each community should have a tie-in to a state computer system and a toll free number to disseminate information. If these missing unidentified children could have been identified through a computer search, they might be alive today.

The Adam Walsh Child Resource Center of Fort Lauderdale, Florida, has sponsored voluntary fingerprinting of children and child abuse speakers programs, and it has established a computerized system for missing children in Broward County, Florida, upon which the state of Florida modeled its statewide system. The FBI is now modeling its computer after Florida's computer system, to trace missing children by physical characteristics.

Through the efforts of the Adam Walsh Child Resource Center, the Florida clearing house now publishes a monthly missing children's bulletin that is distributed to all State law enforcement agencies. Also, the center was instrumental in the passage of a new State law requiring a list of all missing children to be distributed to all Florida school districts. In the case of parental abduction, the likelihood of a child's being enrolled in another school is very high. It is important that all school systems throughout the United States distribute lists of missing children to all school districts.

Our children are our future. We need to protect our children—by voluntary fingerprinting, "safety with strangers" programs, and monitoring court proceedings of child molester cases. Other preventive measures include: keeping a recent photo of your children, a record of a child's scars and identifying marks, dental records, voluntary fingerprinting, and making sure your children know their address and phone number including area code.

The select committee could play a crucial role in a national effort to prevent more Adam Walsh cases. Your support for programs, such as those now in operation in Florida, would go a long way toward ending the national tragedy that could touch any child and family at any time.

Chairman **Miller**. Our first witness this morning will be Mr. Nat Moore of the Miami Dolphins.

Mr. Moore, welcome to the committee.

STATEMENT OF NAT MOORE, MIAMI DOLPHINS

Mr. **Moore**. Thank you.

Chairman **Miller**. We are honored that you have taken the time to come in and talk with us. If you have an opening statement, feel free to make it in the manner with which you are most comfortable. We may have some questions for you.

Mr. Moore. Mr. Chairman, members of the select committee, first of all, I would like to thank you for giving me this opportunity to give my testimony on what has been my life growing up here in Miami, as well as what I see today with the youth of Miami in my everyday experiences. I would guess that, you know, my story is a human interest story. Because I grew up here in Miami, and I feel the need to put something back within the community. I find myself working with different groups, YMCA, for one, the summer camp for two, and trying to give the guidance that I think kept me from going astray as a youth.

We all grew up with a lot of disadvantages as youths. We all wanted to be part of a group of select group of guys or girls or whatever that is supposedly a fun group. You know when I came up here in Miami. the biggest problem I had was trying to decipher who were my friends and who weren't. And when I look back on that day, if it hadn't been for the guidance of some of the coaches that I had as a junior high student, as well as my mother and step-father, that I might be like some of my friends today, who are jobless, uneducated, have spent a lot of time in different prisons.

That is not to say that when I was a teenager that I didn't do things that were wrong, that I didn't take chances or get wild every now and then. But I had some people that I respected that took time out of their busy schedules to say, hey, wait a minute. You know, what you are doing is wrong. Let us re-evaluate the situation. Let us see if we can't find something else to do with all of that energy that you have.

In junior high school I had several friends. First of all, I have always been an athlete. I think that is what has saved me. I had several friends that were better athletes than I, and I have had several friends that also came out of the ghetto here in Miami that have made it. But I had several who were better athletes than myself and some who did make it.

There were guys from broken homes. The way of life was "whatever way I can make it that is what I am going to do." For one guy, you know, he didn't spend as much time with his family as I did with mine. And in a way, sometime you wonder if that wasn't better for him because the background that the guy came from, his entire family was always in trouble. That that was his guidance. That was his leadership.

He had two or three brothers before him who spent time in prison. And I guess it was just his destiny to do the same thing. And he was a very close friend, and I think that if it hadn't been for my mom pulling me away from him at times, that I could have ended up the same way.

Now, when I first went to high school, I had some problems. The first time I had ever been to an integrated school. And coming from an all-black junior high school, I went in with a chip on my shoulder. I felt like the world owed me something. I found myself getting in fights and arguments that really didn't make any sense. But when I was able to go back and talk to an old coach I had in junior high school to make me understand that, you know, the world didn't owe me anything. That I had to go out and get it for myself. That I had to apply myself if I really ever wanted to make it. That was important. And you know, the guy, William Lee and myself—and he is no longer a coach or instructor, he is an insurance man, and you know to me that is sad, because here is a guy that has directed kids' lives for so long in the right direction. And he had to leave the profession that he loved most because of economics.

You look at parents today. With inflation and unemployment, how many parents really have the time to put in with their kids? How many parents actually know what their kids are doing? The last 6 years I have been in teen disco, because when I was a teenager, having something to do on Friday and Saturday night kept me off the streets, kept me out of trouble. And one of my younger disk jockeys came to me once and said, "I got a great idea. Let us have an all-night dance." I said, "What do you mean an all-night dance?" I said, "The kids' parents would have a heart attack." That will show you how naive I was.

I said, "OK, we'll do it. We'll try it. We'll see what happens."

The all-night dance goes from 9 o'clock in the evening until 6 o'clock the next morning. We had over 1,500 kids. At 6 o'clock the next morning we still had over 1,000 kids. And to me, something is wrong. Because even though I did it to satisfy my employees and to see would it work, it was ironic that at that time of the morning the parents would have their kids still out. It got so bad that this was really their only outlet. And I just can't understand today, you know, we talk about the school system, how the doors are closed at 3:15.

Everybody is not an athlete. Everybody is not a drum major or a band participant. But there is what you call extracurricular activities after school. This is something that was available when I was in school that I don't see now. So what do you have kids do? They leave school, they have no jobs. Their parents are working, or whatever. And they have nothing to do but hang out. We all know that no matter how hard you try, if you don't have anything to do but hang out on the corner, someone is going to come up with a bright idea. And usually bright ideas result in trouble.

I am just wondering what happened to the park and recreation facilities that carried teams for people who were not the top athletes, or people who just wanted to come out and play tennis, et cetera. These are the things that I feel today are missing from when I was a kid. You know I had discipline. I had people to care about me. When I was a kid, if I did anybody wrong, not only did I get paddled by the principal of the school, but he also called my mom and she came out and paddled me.

But now, today, you know I go out and I talk to kids in different schools, during Career Week, Black Education Week. And to see the lack of discipline within the school system and the fact that teachers or instructors are so handcuffed, it is amazing that they can teach at all. And I guess this is one of the reasons that, you know, when 3:15 comes, the teachers are the first ones out of the doors.

Hopefully, through these meetings, hopefully we can find some answers to generate some activities for kids so that they don't have to hang out on the bus bench. They can go to the park, and there are team sports or different games, or anything to occupy kids' time. I am a father of three. And I don't get to spend as much time with my kids as I would like to, because of my involvements in different things. The one thing that my wife and I do do is that we make sure when our kids come home from school that we spend time with them doing homework, playing games or whatever.

We make sure that we have dinner together. This was important for me as a kid. Now, I didn't get to meet my father until I was 14 years old. I did not grow up with my real father. But when I was 5 years old my mother remarried and moved to Miami. And the once a month trip to the beach, the once a month trip to the drive-in movies as a familiar was very important to me. It was a time when myself and my four sisters and one brother, my mom and dad, we all worked together. And I think that is so important today, because you know everybody is going in opposite directions, especially the parents and kids.

The parents are so caught up in trying to make ends meet that they don't have time for the kids, especially in the single-parent homes. I had previously planned on bringing a kid here. Very interesting kid; 14 years old, very talented, extremely bright. I have had the pleasure of working with him in the summer gulf coast camp for about 5 years straight. He has been there every year.

The kid comes for a week, has a chance to leave home and spend some time with 150 other kids. And this kid, as small as he is, is probably the best athlete to ever come through there. He is also a great dancer, speaker, you name it. And recently, 3 years ago, I bought a roller skating rink here in the community, and I put the kid to work. And the irony of the whole situation is that he comes from a broken home family where his mother works as a barmaid at one of the local nightclubs. And through all of this he has been able to stay on the straight-and-narrow path, with the fact of his mother going from boyfriend to boyfriend.

He talks to myself and Larry at times about the situation. But the fact that he is able to spend time around people like myself and Larry really helps him a great deal. But the thing that worries me about it is that in the afternoon when he has nothing else to do, he is starting to hang out with the wrong crowd. And for the first time, I guess about a month ago, I caught him smoking marihuana—14 years old.

It is such a waste because all he is doing is trying to belong. He is trying to belong with a group of guys that are in that same neighborhood. Peer pressure. It is something I guess we all go through; not only kids, adults. The fact of trying to belong. When I asked him why was he doing this, he says, "Everybody else does it. You know, I want to be like everybody else."

Hopefully the talk he and I had will get him back on the right track. But it worries me because I am not his dad, and I don't necessarily have the time or will always be there when he needs me. But because he has nothing else to do but hang out, he is starting to get into trouble. He works for me on weekends at my roller skating rink, but what about Mondays through Fridays, when there is no guidance and there is no one there to help him, there is nothing for him to do.

Where are the answers? You tell me. If I had the answers, I would be a politician myself.

Chairman MILLER. That is not the criteria.

Mr. MOORE. But that is basically my story. I guess what I should do is just open up and answer questions from here on in.

Chairman MILLER. One of the things we have learned, Mr. Moore, as we talk to people who work with our children and adolescents, is that it is very easy to learn about the number of children who have failed, the children that end up in the juvenile justice system or drop out of high school. There are ways to measure that.

We do not know as much about children who succeed. Why is it that some succeed and others don't? Why is it that children who live in similar neighborhoods and conditions with regard to family structure and income levels turn out so differently.

I had the pleasure some years ago of taking the new principal of Eastern High School of Washington, D.C., to lunch. I had read about him in the paper, didn't know him, and asked him to come have lunch with me. Eastern High School is about 15 blocks from the Capitol, and at that time was reputed to be one of the toughest high schools in the United States.

We talked about Eastern High School. He said, "we have guns, we have drugs, we have prostitutes, we have cops, we have everybody on our campus, and a few students." He also talked about the fact that he was teaching German, and advanced chemistry, while others were teaching Latin. Some of their students were going out to the various universities for advanced studies.

His student enrollment is made up of 85 percent AFDC children. There is usually only one adult in the home and income levels are very low. Why do some of these kids excel? His answer was that he didn't know, except that when he went to that home, somebody was cheering for that kid, whether it was a sister or a brother or an aunt or stepfather or what have you. Somebody was saying, all right, you got a C. We are all right. You made the team. Or fantastic, you got through the quiz. But somebody was cheering. What you are suggesting today is that when you and I grew up there were role models in a community, people you looked up to. That is not to suggest that they do not exist today.

But the question is whether today the support structure is adequate, especially in neighborhoods where children have more difficult times because of unemployment, poor housing, and fewer role models.

Mr. MOORE. Well, I think role models are very important. When I grew up here as a kid, ironically I hated the Dolphins. I thought they were the worst team in football—which they were.

Chairman MILLER. There is some evidence to that.

Mrs. BOGGS. That was a "Saint-ly" statement.

Chairman MILLER. Not everyone can be a Redskin fan.

Mr. MOORE. But a guy by the name of Jimmy Warren who played for the Miami Dolphins, which I thought was the worst team in football, took time out to come to my high school and speak with the senior class, and afterward spent time with a lot of the athletes in just preparing us for the future, not only for athletics. And to me that meant so much, because it showed that somebody did care. I guess that is basically what I have been trying to do, is be a role model. Be around the kids for whatever reason it might be. If nothing else but to just sit there and say hello, and carry on a conversation.

I find myself trying to get more players involved within the community with reference to coming out and spending time with the kids. When I opened up my roller skating rink it was both for profit, as well as trying to help the community. With the idea that if I can get some of my teammates, the A. J. Deweys, Tony Nathans, the Tom Bowers, that if these guys would come out and spend some time with the kids, the impression it would make on the kids.

Now, I know that everything starts at home with reference to helping a kid. You have got to have that support, from your family, your parents or from whatever. And I think that guys like myself, people who have made it, who are a sign that you can get out, there is a light at the end of the tunnel. It is important for us to be a part of it. But the problem as I see it, and I could be wrong, in reference to trying to get these type of things sponsored or put on, we haven't been able to. I have talked to several individuals about the athletes in the off-season doing clinics.

Let us face it. There is not much you can teach kids in 1 hour about football. That is not where my head is. My head is in the fact of getting eight or nine, at least, each weekend to go to Broward County, Dade County, and just spend some time with the kids because, you know, when kids see that you care, and that you have made it, they start to think that they can. When I saw Jimmy Warren, I felt like I could be a professional football player.

The guy was no bigger than me. I was 160 pounds in high school, he was 175. I am saying, well, if he can make it, what is to keep Nat Moore from making it. I have talent. I have brains. And if we can't get the parks and recreation facilities open so we can come in and do these type of things, it is a problem. It turns the athletes off because they have other things they would like to do as well.

Half the time we can't get transportation. Everybody wants it to be at their park. Someone's got to bus kids somewhere. We went through it this year during, last year, shall I say, during the strike. We tried to run a couple clinics. They went fairly decent when we were able to get them established. But the problem still stems from everybody wants to take the credit, but nobody wants to do the work. And who suffers? The kids.

Chairman MILLER. Mrs. Boggs.

Mrs. BOGGS. Thank you, Mr. Chairman.

Mr. Moore, thank you so much for taking your time this morning to be with us and giving us your valuable testimony. I, too, had a stepfather when I was 5½, and he was the most stabilizing, wonderful and supportive influence in my life. I realize what a fine model your stepfather must have been for you and your siblings. That has come through loudly and clearly—that children need the image of a person they can respect and admire who loves them sufficiently well to discipline them.

And did your mom make you pick out your own switch? Mine did. What really is concerning me here mostly is the question of economics. What you are saying is that we hear this great huge national push about education, about whether we should have merit pay for exceptionally good teachers. Do we need to reach out and make certain we have merit pay for our science and math teachers to lure them from the private sector, and so on.

Apparently it is a question of economics. If we don't pay those talented teachers, such as that coach, sufficiently well so that for his own family's sake can't afford to remain in the profession he loves, is it a question of economics? At 3:15 we lock the gates to the schools and don't have the teachers there who would be willing to give their time and their talent to give a study hour, maybe shop, maybe arts and crafts as well as athletics? Shouldn't we address the problem of school closings, and the loss of the teachers, from some realization that communities must feel that they can afford to have the kind of teachers and extracurricular activities that are needed?

Mr. **Moore**. I would say that possibly the problem is, as you say, underpaid teachers, people who really do care that can no longer stay within the school system because of financial problems. Somewhere in there we have got to find a way to pay the teachers enough. I mean we are talking about people who educate our kids, and they are the lowest paid people in the process. You know, when I was a senior in high school, because of economic reasons we had people coaching sports that had never coached, played, and had no idea what that sport was all about.

But they needed the coaching supplement. They needed that extra money to make ends meet so they could stay in teaching. The most ironic thing I have ever seen is to have a swimming coach who couldn't swim. But we had this. I mean the kids eventually taught him to swim. You know, he was a great English teacher, and he needed the coaching supplement to be able to continue to teach.

Now, you know, we had funds directed at all these different avenues and we came up with all these different programs where we gave kids jobs, et cetera. But I think that education, first of all, is the road to success. Because awareness is the key. I mean, I talk with kids a lot when I go through Career Week. And you will be surprised how many kids today have no knowledge at all, or have no feeling as to what they want to do in life.

They are going through the motions. And I did it early in my life. But you would think today that, 15 years later from when I was in high school, that the kids would have some general concept of what they would like to do or some role model they would like to follow. But they don't. So it has got to start at home and within the schools. From there, everything filters out. If we can find some ways, I mean we can't give everybody jobs. That is evident.

But I think when we are talking about educating the leaders of tomorrow, somewhere in there we have got to generate some funds for education, for teaching, to make teaching worthwhile to the instructors.

Mrs. **Boggs**. Thank you so much, Mr. Moore.

Chairman **Miller**. Mr. Bliley.

Mr. **Bliley**. Thank you, Mr. Chairman. I just want to thank Mr. Moore for sharing his thoughts and valuable time with us as we grope with these problems. I don't have any questions.

Chairman MILLER. Mr. Lehman.

Mr. LEHMAN. Thank you, Mr. Chairman. I think Mr. Moore personifies the quotation, "Better to light one candle than curse the darkness." And that is your story as far as I am concerned. That too many of us are cursing the darkness of our community rather than to try to light one candle to help one boy. I think that is the way out of this predicament we sometimes find ourselves bogged down in. I will talk to you at some other time about paddling because I disagree with you on that.

I would also like to talk to you further about the fact that the program is oriented toward mainly young men. I think that just adds to the problem. I don't want to take up any more of your time now. But perhaps our staff can work something out with you. We can have a luncheon together or something and maybe bring a few people together from around here and help you with your efforts because certainly your candle can be increased to a 1,000-watt bulb with a little help from people in this area.

Thank you.

Chairman MILLER. I want to thank you very much for taking your time to be with us. I think that you have laid some of the fundamental issues certainly with respect to our children, right before this committee. I also want to thank you in your capacity as the representative of the Players Association. Congresswoman Boggs and I have enjoyed the support of the Players Association on a number of pieces of legislation, including those dealing with domestic violence, child abuse, and spousal abuse.

Also, I have had an opportunity to work with a number of people who are graduates of the Players Fellowship Camp. It is quite remarkable. These are young people who have taken a second look, as you say, at what they want to do with their lives and many have turned out to be exciting success stories.

Thank you very much. You don't mind if I still hope for the 49'ers to stay one game ahead of you all the time.

Mr. MOORE. Thank you.

Chairman MILLER. Thank you very much for your testimony.

Mr. MOORE. Thank you.

Chairman MILLER. Next the committee will hear from a panel made up of Marcia Weaver, who is project coordinator for the Mississippi Chapter of the American Academy of Pediatrics; Don Crary, executive director, Arkansas Advocates for Children and Families; Eva LeGard, member, East Baton Rouge Parish School Board and member of the Governor's Task Force on Priority Setting for Education in Louisiana; and David Pingree, secretary, Department of Health and Rehabilitative Services, Florida.

Welcome to the committee. If you have a prepared statement, it will be put in the record in its entirety. To the extent to which you can summarize, it will be appreciated by the committee.

We will hear from Marcia Weaver first.

STATEMENT OF MARCIA WEAVER, PROJECT COORDINATOR, MISSISSIPPI CHAPTER, AMERICAN ACADEMY OF PEDIATRICS AND FORMER COMMUNITY PLANNER, GOVERNOR'S COMMISSION FOR CHILDREN AND YOUTH, MISS.

Ms. WEAVER. Mr. Chairman and members of the select committee, I am pleased to come before you today to tell you about some of the problems Mississippi's children and their families face. What I will describe focuses on prevention, not the more expensive crisis-oriented supports.

Mississippi is on the move. We lead the Nation in education reform, before "Nation at Risk" swept the country. Mississippi is investing in its own future.

The State legislature passed an Education Reform Act in December 1982, including a sales tax increase. The board of higher learning has increased college entry level standards calling for more math, science, and foreign languages.

The board of economic development has planned an aggressive program for selling our heritage, resources, and potential for industrial growth to in-State visitors and to companies considering relocating.

Vocational and technical education was recently reorganized in Mississippi.

Approximately 809,000 children are among the most valuable of our plentiful resources in Mississippi. Some children are well provided for from the very beginning of life. Some are not.

Mississippi has the highest teenage pregnancy rate in the Nation.

Mississippi has the second highest infant death rate in the Nation; 155,000 children live with only one parent; 33 percent live below the poverty level; 39 percent live in deteriorated housing; almost 100,000 children under age 6 have mothers who work and over 28,000 children are without licensed care while their parents work.

Mississippi has the highest school dropout rate in the Nation. Military rejection rates are the highest in the Nation. Mississippi has the lowest per capita income in the Nation.

Unemployment has been above 10 percent for 21 months.

Mississippi has been counting on the predicted economic recovery. Unfortunately, those anticipated revenues have not yet come to Mississippi. Last week our tax commission reported that $52.5 million were short in anticipated State revenues in the first 3 months of the fiscal year. State budgets have already been cut 5 percent. State public officials must begin to make some devastating choices.

Let me tell you how some of the congressional decisions are affecting three families that live in Hinds County. Cloteal, with her husband and 9 of her 11 children, moved back to Mississippi 3 years ago to be close to family. Cloteal is a domestic worker, head-of-household with an eighth grade education. Before their return to the State, her earnings were supplemented with AFDC. Cloteal's husband receives disability. In Mississippi, they were not eligible to receive this entitlement.

Cloteal desires to do better but in her own words "My hands are tied." Her hope is that her children can get an education preparing them for good jobs so that they are not bound with the problems she has faced. Recently Cloteal borrowed out of the family budget and from her church $301 to pay for books, fees, and transportation for one son to enter a local junior college in September.

Cloteal and her family depend heavily on food stamps. With the proposed monthly reporting any change in her $62 weekly earnings will have to be reported. At the very least her food stamps will go up or down every month.

What is expected from the new reporting system? From a 4-month pilot in six Mississippi counties, the State welfare department found that about 70 percent of the clients reported some change. Ten percent lost food stamps because they did not meet the reporting deadline. At best, the cost of administering the program breaks even with the cost savings. However, this is because of the savings of withholding stamps from those who could not get their paperwork completed on time.

Shirley is a 29-year-old mother of three children. Her first two children were delivered by Caesarian section by her obstetrician at a local county hospital just a few blocks from her Jackson home.

When Shirley was in the second month of her third pregnancy her husband lost his job as an offshore oil driller. With the loss of his job came the loss of the family's health insurance. The family took all of their savings to pay the obstetrician. Then they visited the finance office of the hospital where they were told not to come back until they had at least half of the cost of the C-section delivery.

The Mississippi State Legislature secured passage of the first limited medically needy bill in the country. Funding was delayed until July 1984. Now because of Federal reductions in medicaid matching rates, Mississippi is faced with a $10 to $12 million State budget deficit which will mean a $43 million program reduction if additional State funds are not appropriated. This puts in jeopardy the potential funding of limited medically needy.

Juanita is a success story. Juanita is a single mother who grew up near Utica with her mother, grandmother, and three siblings. She completed high school, junior, and senior college. Now Juanita is employed as the coordinator of the WIC program housed at a rural health clinic nearby.

Juanita's daughter has caught the spirit. Her oldest child recently scored above the 95th percentile on the California Achievement Test. Her school is dependent on both State and Federal funds. Ninety-one percent of the students at her school receive free or reduced lunches.

Public school support is key if Juanita's child is going to make it. Tax tuition credits will encourage more students to leave the public schools. There is no child care facility available to Juanita for her 3-year-old in this rural communtiy. Child care is difficult for working mothers to find in rural Mississippi.

What is the responsibility of the Federal Government to Mississippi families? Essentially, it is to provide certain services for the Nation's advancement. Mississippi, a high risk State and at best only able to provide the very basics, is still, unfortunately, the poorest State. We are trying to help ourselves, yet we continue to need assistance from the Federal Government.

In our State there are too many people who lack the basic security to be able to progress steadily toward self-sufficiency. Only when all our people can see the hope of self-sufficiency can the State move out of its impoverished status.

I ask that this committee give full consideration for continued support to Mississippi in the areas of health care for mothers and babies, public schools for educating our children and supports like food stamps and child care. Mississippi is counting on your leadership, your direction to provide the policies to encourage self-sufficient families.

Thank you for kind attention and for allowing me to testify before this committee.

Chairman **MILLER**. Thank you.

[Prepared statement of Marcia Weaver follows:]

PREPARED STATEMENT OF MARCIA WEAVER, MISSISSIPPI

Mr. Chairman and members of the Select Committee. I am pleased to come before you today to tell you about some of the problems Mississippi's children and their families face. As a native Mississippian, who has worked with and for children and their families for over twenty years, I would like to talk with you about cost-effective programs that encourage self-sufficient families. What I will describe focuses on prevention, not the more expensive crisis-oriented supports.

Mississippi is on the move. We lead the nation in education reform, before "Nation at Risk" swept the country. Mississippi is investing in its own future.

The state legislature passed an education reform act in December 1982. Comprehensive features of the act include salary increases for teachers, kindergarten, compulsory attendance, accreditation and certification improvements, school consolidation study, and professional development for school administrators. To pay for these improvements, the sales tax was increased. Already the state has hired reading aides for all first grade classes, hired and trained school attendance counselors, and appointed a commission to set new teacher education and certification standards.

Additionally, the Board of Higher Learning has increased the college entry level standards calling for more math, science and foreign languages.

The Board of Economic Development has planned an aggressive program for selling our heritage, resources and potential for industrial growth to in-state visitors and to companies considering re-locating.

Vocational and technical education was recently reorganized in Mississippi. This will provide a match between training institutions and industrial needs. A direct result of this state effort was the Tuesday, October 10 announcement of a Hughes Aircraft expansion in Forest, Mississippi.

Mississippi has an excellent record in health immunization. Ninety-eight percent of all school age children have received basic immunizations. Numerous other health care services are provided with emphasis on prevention. A wide range of services are avaiable statewide such as children's medical program, family planning, home health services, WIC and services provided by Medicaid. Most of these services are available through state and federal match.

Approximately 809,000 children are among the most valuable of our plentiful resources in Mississippi. They constitute almost one-third of the state population. Some 257,000 are under six years of age. The 46,000 children that will be born this year in Mississippi will reach the age of majority in the year 2000.

However, all is not well.

Support systems surrounds children from the moment of conception. Some children are well-provided for from the very beginning of life. Some are not.

—Mississippi has the highest teen-age pregnancy rate in the nation
—Mississippi has the 2nd highest infant death rate in the nation
—155,000 children live with only one parent
—33 percent live below the poverty level—39 percent live in deteriorated housing
—Almost 100,000 children under age six have mothers who work
—Over 28,000 children are without licensed care while their parents work
—Mississippi has the highest school dropout rate in the nation
—Military rejection rates are the highest in the nation
—Mississippi has the lowest per capita income in the nation
—Unemployment has been above 10 percent for twenty-one months

Mississippi has been counting on the predicted economic recovery. We were counting on Sunbelt growth. We were counting on more people out of state willing to invest and live in Mississippi.

Unfortunately, those anticipated revenues have not yet come to Mississippi. No real growth has occurred. Unemployment remains over 12 percent. Mississippi is in the shadebelt. On October 6, last week, the Mississippi Tax Commission reported that Mississippi was $52.5 million short of anticipated state revenue in the first three months of the fiscal year. State budgets have already been cut five percent.

The cut-back philosophy at the federal level is hitting Mississippi like a ton of rocks. In 43 of the states' 82 counties, transfer payments are the largest source of income.

State public officials must begin to make some devastating choices. Do we continue to maintain Medicaid standards at the state mental hospital or do we cut highway spending? Do we support good prenatal care and delivery or provide physics teachers in rural Mississippi schools? Do we pay court incurred obligations or do we hope the justice department will hold the tab a while longer? The decisions are difficult.

Let me tell you how some of the Congressional decisions are effecting three families that live in Hinds county. Two families live in Jackson, the state capitol and a rather progressive, well-to-do community. The other family lives in Utica, a small town of 867 people who proudly reported four weeks ago the installation of its second stop light. Two of these families are black. One is white.

Cloteal, with her husband and nine of her eleven children, moved back to Mississippi three years ago to be close to family. Cloteal is a domestic worker, head-of-household with an 8th grade education. Before their return to the state, her earnings were supplemented with AFDC. Cloteal's husband receives disability. In Mississippi, they were not eligible to receive this entitlement.

Cloteal desires to do better but in her own words "My hands are tied." Her hope is that her children can get an education preparing them for good jobs so that they are not bound with the problems she has faced. Recently Cloteal borrowed out of the family budget and from her church $301.00 to pay for books, fees and transportation for one son to enter a local junior college in September. That money will be difficult to repay.

Cloteal and her family depend heavily on food stamps. With the proposed monthly reporting any change in her $62.00 weekly earnings will have to be reported. If she misses a week of work or picks up an extra job, or simply finds a fifth payday in a month, she now has to report that change. At the very least her food stamps will go up or down every month. If she makes an error or the report is late, their food stamps will be cut off. Cloteal's case will be closed and she will have to apply for recertification, a delay of a month or two. Even worse, her son will likely have to drop out of school so they can eat.

What is expected from the new reporting system? From a four month pilot in six Mississippi counties, the State Welfare Department found that about 70 percent of the clients reported some change. Ten percent lost food stamps because they did not meet the reporting deadline. Some automatic changes occured. Rather than a basing eligibility on a standard pay period such as 4.3 pay periods per month, monthly reporting will have some four and five week pay days per month. At best, the cost of administering the program breaks even with the "cost savings". However, this is because of the "savings" of witholding stamps from those who could not get their paperwork completed on time.

Implementation of the monthly reporting for food stamps has been delayed. If enacted, Cloteal and her family will be significantly affected. Changes in persons and income in her home do change from month to month. Just understanding the paper work and completing the necessary reporting forms on time become primary to their survival and can eliminate hopes for her children to ever become self sufficient.

Shirley is a 29 year old mother of three children. Her first two children were delivered by Caesarian section by her obstetrician at a local county hospital just a few blocks from her Jackson home.

When Shirley was in the second month of her third pregnancy her husband lost his job as an offshore oil driller. With the loss of his job came the loss of the family's health insurance. The family took all of their savings to pay the obstetrician. Then they visited the finance office of the hospital where they were told not to plan to come back to the hospital without at least $1000 of the $2000, necessary for a C-section delivery.

The social work department suggested that Shirley might be able to deliver as an indigent patient at University Medical Center. But her doctor told her he did not have staff privileges at that hospital. He advised her to come to the county hospital emergency room when she was in labor where he would meet her. After finding no other resources Shirley went to emergency where the physician arranged admission. Despite the two previous surgical deliveries, her baby was delivered normally one evening. Concerned about how she would ever pay the bill, the next morning Shirley picked up her baby and went home, against her doctor's advice.

With the help of Shirley's testimony, advocates were successful in the 1983 state legislature in securing passage of the first Limited Medically Needy bill in the country. Funding was delayed until July 1984. Now because of Federal reductions in Medicaid matching rates, Mississippi is faced with a $10 to $12 million state budget deficit which will mean a $43 million program reduction if additional state funds are not appropriated. This puts in jeopardy the potential funding of Limited Medically Needy.

The Congress is now considering proposals which could help Shirley. Representative Waxman has proposed 100 percent Federal funding for married poor women with unemployed husbands and health care benefits for their infants. (HR 4059) Federal proposals are also being considered to reduce the cost-shifting to the states in the Federal matching formula.

Juanita is a success story. Juanita is a single mother who grew up near Utica with her mother, grandmother and 3 siblings. She completed high school, junior and senior college. Now Juanita is employed as the coordinator of the WIC program housed at a rural health clinic nearby.

Juanita's daughter has caught the spirit. Her oldest child recently scored above the 95th percentile on the California Achievement Test. Her school is dependent on both state and Federal funds. Ninety-one percent of the students at her school receive free or reduced lunches.

Public school support is key if Juanita's child is going to make it. Close by there is a private school attended by all white students. Tax tuition credits will encourage more students to leave the public schools diluting both community support and dollar values. In Mississippi 86 percent of our children attend public school and dollars are distributed on a per pupil basis. Tax credits would offer little choice to families like Juanita.

There is no child care facility available to Juanita for her three-year-old in this rural community. She is completely dependent on a friend or relative to keep her baby. When grandmother, who is almost 70 years old, is ill Juanita has to be absent from work if she is not able to locate some place to take her child for that day. Child care is difficult for working mothers to find in rural Mississippi.

Juanita needs consistent available child care. Federal initiatives to expand family child care and employer-sponsored child care are vital in rural communities where mothers must have child care to be self sufficient.

What is the responsibility of the Federal Government to Mississippi families? Essentially, it is to provide certain services for the nation's advancement.

For the first time in my lifetime there is a united effort for economic progress for all of our citizens. State policies have been established to invest in people and prevention rather than treat neglect. To encourage self-sufficiency, policies such as the Education Reform Act and the Limited Medically Needy expansion of Medicaid were enacted.

Mississippi, a high risk state and at best only able to provide the very basics, is still unfortunately the poorest state. We are trying to help ourselves, yet we continue to need assistance from the federal government. High tech is slow coming to Tylertown, Wiggins and Itta Bena.

The state's history of civil rights conflict is rapidly changing. Opportunities for black citizens are better than ever. Yet educational and economic differences between blacks and whites are still significant.

In our state there too many people who lack the basic security to be able to progress steadily toward self sufficiency. Only when all our people can see the hope of self sufficiency can the state move out of its impoverished status.

I ask that this committee give full consideration for continued support to Mississippi in the area of health care for mothers and babies, public schools for educating our children and supports like food stamps and child care for families, to the greatest extent possible. Cloteal, Shirley and Juanita and hundreds of thousands in Mississippi are counting on your leadership, your direction to provide the policies to encourage self sufficient families.

Thank you for your kind attention and for allowing me to testify before this committee.

Chairman MILLER. Mr. Crary.

STATEMENT OF DON CRARY, EXECUTIVE DIRECTOR, ARKANSAS ADVOCATES FOR CHILDREN AND FAMILIES, LITTLE ROCK, ARK.

Mr. CRARY. Mr. Chairman and members of the committee, thank you for giving me a chance to be here today to talk some about Arkansas children and their problems. I perhaps should have conferred with Marcia ahead of time, the problems sound so similar between Mississippi and Arkansas. In the brief time I have I want to cover three fairly big areas of children's programs and services that currently are not being adequately provided for and are causing enormous problems to children and youth in Arkansas.

I am going to cover them generally in my opinion in the order in which the tragedy of not meeting the needs is greatest, and also in terms of the greatest number of children affected. The first clearly in Arkansas, as mentioned with Mississippi, is basic income and health support programs for poor children in the State. One out of four children in Arkansas lives in poverty. That is a huge percentage. Arkansas established its standard of need for AFDC in 1976, and has never adjusted it since that time.

At that time we decided to pay 69 percent of it as payment level and since then have lowered that to 60 percent. Therefore, today in Arkansas a mother with absolutely no other source of income and three children to take care of gets $164 a month. None of you, not myself, and no one in this room can pay for rent, water, electricity, gas, transportation, clothes for three children and basic household supplies that wouldn't be covered under food stamps on $164 a month.

If that mother, out of concern for her children, seeks some form of additional income, borrows income from neighbors and relatives, clearly, the choices, she reports it and has benefits reduced, she doesn't report it and stands the risk of a fraud investigation. If she doesn't seek additional income, can't continue to pay rent and utilities and provide for her children, she obviously runs the risk of State investigating. Investigating for neglect of the children who may be seriously neglected.

And it is interesting to note that if in fact we took her children, we would put them in foster care and pay someone else $400 a month to take care of her three children. It is an absurd system and has incredibly tragic consequences on families in Arkansas. Related clearly are the problems of health care because medicaid has been tied to AFDC. If you have low standards for AFDC you also have thousands of children not getting health care, which is the case in Arkansas.

We have literally thousands that don't qualify because the standard of need is so outdated in Arkansas. We also do not cover the unemployed parent so we do not provide those kinds of programs for poor people if there are two parents in the household. Thus, in periods of high unemployment if a husband loses a job, cannot find another one, the family desperately needs financial assistance from the State, the option is to abandon the family. Again, that has to be true abandonment or risk fraud in order to provide for his children.

We also do not cover prenatal care for first time pregnancies. This is a critical problem in poor areas and for poor children throughout the State; there is a desperate need for providing good prenatal care. In my mind it obviously is also the most cost-effective way to spend health dollars I can name. Prenatal care is relatively inexpensive, especially when you compare it with the cost of caring for premature, low-birth-weight babies at $1,000 a day. You do not need that for women covered with prenatal care for a great number of women.

It would be of tremendous benefit for the Federal Government to require States to periodically adjust their standard of need or to set a minimum level that is acceptable as a national level of income that families ought to be able to have when circumstances leave that their only source of income.

The second area I wanted to mention has to do with child welfare services. In Arkansas we have the greatest problem in the area of preventive services. We simply don't have an array of services to keep children in their own homes. Part of that obviously is economics, as I said before. Our emergency assistance fund is so poorly funded in the State of Arkansas that at best a family may get a $40 one-time emergency assistance check. That clearly is not going to help a family being evicted from an apartment or who has a utility being turned off, someone who needs to overcome that financial problem to care for their own children.

We also do not have nearly enough day care. We have 22 homemakers covering 16 of the 75 counties in Arkansas. We clearly, as I think was recognized throughout the Nation in Public Law 96-272, are continuing in Arkansas for most of the child welfare funding to go into out-of-home placements. Our hope is that that law [96–272], if it stays intact and has its own monetary appropriation, will provide monetary incentive to redirect efforts toward prevention. But it will be important for it to remain a separate act to provide that incentive.

The third area I want to mention is the problem of juvenile justice in Arkansas. The biggest problem we have is an antiquated juvenile court system in which at least a fourth of the judges in juvenile service have no legal training. In addition probably 90 percent of the remaining juvenile courts have part-time judges also maintaining a full-time legal practice. So obviously the priorities come out often in terms of where one's livelihood comes from, which is more often the legal practice than the juvenile court judge's role.

We also have concurrent jurisdiction for juvenile court and criminal court for 15- to 19-year-olds and with the prosecutor making the choice of where the trial will take place. Provisions of the Juvenile Justice Act which mandate the unjailing of juveniles does not really protect these kids because the act has essentially defined juveniles as kids under the jurisdiction of juvenile court," which these kids are not once they have been charged as adults.

So for many of those children who are continuing to be sent through adult courts and end up in adult jail, I would like to see the Juvenile Justice Act be more specific in its definition. That a juvenile be a specific age group. And if there is a need to allow for some kind of concurrent jurisdiction adult court, that it [the JJDP Act] specify violent and serious offenses—which only 10 percent of the kids going through the courts in Arkansas have committed.

I appreciate the opportunity to be here. Clearly Arkansas children have some very severe problems. It is, as Mississippi is, a very poor State. I would be the first to argue Arkansas has not done what it can do for the children and youth of the State, but I also recognize it has limited resources, and in reality may never do all that is necessary without the assistance of the Federal Government.

It is a great pleasure for me and the people who care about children and youth in Arkansas to know that there is a Select Committee on Children and Youth that we can discuss the problems with.

Thank you.

Chairman MILLER. Thank you.

[Prepared statement of Don Crary follows:]

PREPARED STATEMENT OF DON CRARY, EXECUTIVE DIRECTOR, ARKANSAS ADVOCATES FOR CHILDREN AND FAMILIES

Mr. Chairman, members of the committee, I am Don Crary, Executive Director of Arkansas Advocates for Children and Families. I would like to express my gratitude to you for allowing me to be here today and for your concern for the children, youth and families of Arkansas.

Though there are many problems facing large numbers of Arkansas children, I will review for you only three or four major areas of concern. These areas are: (1) the impact of basic financial and health support programs on children, (2) the current child welfare system in Arkansas, and (3) the current juvenile justice system.

Basic financial and health support programs

Thousands of Arkansas children are living lives of abject poverty, with all the known consequences of such a life. In fact, almost one of every four children in Arkansas is currently living in poverty. Many of these children live in homes with inadequate heat and water, have too few clothes to stay warm in the winter, and too little food to be free from hunger. The programs designed to help these children, primarily AFDC (Aid to Families with Dependent Children) and Medicaid, are woefully inadequate.

The Arkansas AFDC "standard of need" was determined 7 years ago. The state, at that time, established the AFDC payment rate to be only 69 percent of the standard. In spite of the enormously high rates of inflation causing prices for all necessities to increase, Arkansas has never adjusted its standard. We have, however, dropped our payment to only 60 percent of that standard. We now provide a single mother, with no other source of income and three children to care for, $164 per month. Surely, no one in this room nor that mother can pay rent, gas electricity, water bills, pay for transportation, and purchase clothing for three children on that amount of money. But if this mother, out of concern for her children, seeks and receives assistance from somewhere else, either her AFDC will be further reduced or she may be charged in court with fraud. A more tragic consequence, however, is that when she fails to provide her children with the basic necessities, a social worker may investigate her for "neglect" and possibly seek the removal of her children and their placement in foster care (where, by the way, we will pay other people $400 per month to care for the same children.)

An additional tragedy, with unemployment rates extremely high in Arkansas, is my state's refusal to participate in the "unemployed parent" AFDC program. Currently, if a father loses his job, cannot find another one, and his family needs financial assistance through AFDC, he must first abandon his wife and children. Again, he must actually abandon them or risk being charged with AFDC fraud. It seems tragic to me that we would demand that a father desert his family in order to provide for them.

Unfortunately, for children in Arkansas, Medicaid eligibility is tied directly to AFDC eligibility—the maximum income being 150 percent of the state standard of need. Since our standard is unrealistically low, so is our eligibility or Medicaid. Thus, thousands of children in Arkansas are essentially without basic health care and are, therefore, at risk of developing critical illnesses and perhaps even life-long disabilities which might otherwise be prevented—an obvious waste of human potential and needed dollars. Further, Arkansas does not offer Medicaid coverage to poor women until the birth of their first child—when they become AFDC eligible. Thus, many of the poorest women in Arkansas cannot afford and do not receive prenatal care resulting in increases in the number of premature births, low birth weight babies, and babies born with some preventable defect. Again, such pregnancy outcomes are both tragic and expensive.

I would urge you, for these children in Arkansas, to give serious consideration to requring states to make periodic adjustments in their standard of need and to mandate Medicaid coverage for first-time pregnant women from the date of pregnancy confirmation.

Child welfare services

The second area I want to focus on is child welfare services. I use this broad term to cover all of the services traditionally associated with the handling of child abuse and neglect: preventive and protective services to enable children to remain with their natural families, foster care services for children who must be removed temporarily from their homes because of the severity of the abuse or neglect, and adoption services to place children with another permanent family when they cannot be returned to their natural parents. Surely no children are more vulnerable than those at risk of being taken from their families and put in state custody.

Yet, in Arkansas, very little is done to maintain these children in their own homes. We have twenty-two homemakers covering 16 of our 75 counties. we have virtually no intensive in-home counseling; we have only a small fraction of the protective service day care needed; and we have an emergency assistance program which is so poorly funded that, at most, those families which I mentioned earlier (who may lose their children for lack of financial resources) may receive $40 in an emergency payment.

Our hope is that the provisions of Public Law 96–272, with its emphasis on prevention, will push Arkansas to develop these missing services. For Public Law 96–272 to do so, however, it is important that it remain a separate ACT with its own appropriation and that it not become part of a Block Grant. I am convinced that only the fiscal incentives provided in Public Law 97–272 will force the development of new and desperately needed preventive services in Arkansas. Hopefully, Public Law 96–272 with its focus on the quality and frequency of judicial reviews for children in out-of-home placements will also serve to force many of the changes needed in the juvenile justice system of my state.

Juvenile justice

The Juvenile Court System in Arkansas is perhaps the most antiquated, and most damaging, of any in the nation. We have seventy-five juvenile courts, one in each county. More than one quarter of these courts are presided over by a "judge" with no legal training and 90 percent of the others have judges who are part-time and, therefore, also actively engaged in their own legal practice. Further, the Supreme Court in Arkansas has failed, or refused, to establish rules of procedure for juvenile courts. It is, as some have said, "justice by geography" where what happens to children and families is more dependent upon where they live than the charge against them.

In addition, any child 15–18 years of age may, at the discretion of the prosecutor in the county, be charged for a crime and sent to adult court rather than being charged as a delinquent in juvenile court. In 1981, 47 percent of the juveniles in Arkansas were sent to adult rather than juvenile court. The consequences of this are that thousands of juveniles are held in adult jails before trial, sentenced to adult jails following trial, and acquire a criminal record. Unfortunately, for these youth, the Juvenile Justice and Delinquency Prevention Act which prohibits the jailing of juveniles has defined "juvenile" as youth under the jurisdiction of juvenile courts. Obviously, to be of significant benefit for large numbers of our youth, the Act needs to use an age definition of juvenile. It would also be of great benefit to Arkansas youth for the J.J.D.P. Act to specify that the due process rights due them are provided for each youth, and for the Juvenile Justice monies to be tied to a state's compliance with those provisions.

In conclusion, let me say that there are numerous other problems: a 35–45 percent school dropout rate, an enormous shortage of affordable child care for the working poor, very few services for multiproblem or emotionally disturbed youth, to list a few on which I have not had time to elaborate. In all areas, however, the role of the federal government in helping solve the problems is a critical one. Arkansas is an extremely poor state. Though I would be the first to argue our state has not done all it can to meet the needs of its children, the fact is it lacks the resources to do all that is necessary. The importance of the federal government in mandating the services needed for children in may state to have the same opportunities as children of other states, and in providing the financial assistance needed to make such services possible cannot be overemphasized.

I appreciate the opportunity to share my concerns about children and families in Arkansas with you and look forward to the results of your committee's work.

Chairman **MILLER**. Eva.

STATEMENT OF EVA LeGARD, MEMBER, EAST BATON ROUGE PARISH SCHOOL BOARD, AND MEMBER, GOVERNOR'S TASK FORCE ON PRIORITY SETTING FOR EDUCATION IN THE EIGHTIES, LA.

Mrs. **LEGARD**. Thank you. Good morning.

Mr. Chairman, members of the committee, thank you very much for giving me the opportunity to address you this morning. I am going to only talk about four of the subtopics which I have listed, as after hearing your opening statements, and testimony from the others, I am going to try to bring to focus what I really hear in connection with what is being discussed.

Chairman **MILLER**. The people in the back of the room are unable to hear you.

Mrs. **LEGARD**. Is that better? I am going to talk first about curricula. The inner city schools have traditionally received old, outdated books, instructional materials and supplies passed on from the affluent areas, which in many instances could not be of benefit to the college bound student. These ills were brought to public focus when schools were desegregated. However, parents had been echoing these facts all along. Every Tom, Dick, and Harry has a pet project he wants to experiment on poor and minority students.

Of course when desegregation came about, students were sent in many instances 20 miles into suburbia. He got into the other school where he was clustered. He became confused and disturbed with the fact that where he was an A student previously, now he may be a C student, or he may be a failure. Not necessarily because he couldn't read or didn't understand, but because he had been taught on the level that, on a level much inferior to what was being taught in the school where he had been transferred.

So it becomes a problem. He becomes a problem. He is suspended and is sent home and gets into the street with other boys and girls. And naturally they become prey to drugs and other things. So something we feel as parents, by the way, I am a mother of 12 and this is why I am speaking from this perspective because it does concern me tremendously. And parents in inner city schools feel that the books, materials, and supplies which they are using and the experiments that are being done with the special project should cease and something should be done about that.

On student suspension—we are talking about Baton Rouge right now—and let me say we have a very good school district. We have very good student attendance. We have some good teachers and good principals, but we do have some that are insensitive and we do have some problems and these are the problems I am addressing, not necessarily condemning all of them.

In addition to the 56,000, we have approximately 15,000 students suspended. Of course if a child is not in school, he cannot learn. If he is in the street he is going to be prey for every ill in that community. This has been the major, major reason for many of the suspensions were very minor such as chewing gum, talking in school and tardiness. Many times the children are tardy because the buses were late. And if the bus is late, picking up the students, sometimes they are not there for 2 hours.

The mother has gone to work. If the parent has gone to work, if the bus is late, many don't have someone to contact the school bus transportation office to see they are picked up. So what do they do? Mom thinks he is in school. He is out there headed for trouble. So we need alternatives.

First, we need to have some alternative to suspension. And I don't know how we are going to handle the students whose parents have put them on the corners to catch their buses and they have to go to work and the student never goes to school. I don't know how you are going to handle that, but we do need to have alternatives to suspensions. We do have one form of alternative, but we have that in only about five schools. The other schools have no alternative programs so these kids that are suspended are in the streets.

Then I talk about incentive educators and ignorance of school board policy. Many times students are suspended not because of any real reason that he has but because he has broken school board rules. Many principals who are promoted don't even know what the school board policy is themselves.

I would like to give you one illustration. I sat in on a hearing, which I am not supposed to do. But then I was elected to represent my district, parents and children; and as a mother of 12, I felt a need to find out why so many students were being suspended. One parent called and asked me if I would please come and sit in on a hearing. And I did. Of course I was told that you can't make policy and implement policy at the same time. And I agree with that. But in sitting in on this policy, first of all, the teacher was extremely wrong. The child had a cut on his arm which had been stitched. The teacher pulled him on the arm. The child tried to explain to her, please don't, I'm hurt. But of course we have some school districts, the teacher is never wrong. I am not saying that, and I am not condemning teachers and I am not speaking in favor of parents against teachers, because we have many, many good teachers and we have many bad parents. We also have many good parents.

But the principal who brought the child in did not give the child an opportunity to explain. Simply said Jane said this is what happened and you are expelled for 20 days.

Now, in Louisiana just recently the Board passed a policy that if a student misses 10 days he must automatically fail. This policy was handed down about a week after school had opened. Students don't come to school, many of them, until after Labor Day, which means that these students who were not in school prior to Labor Day were already in jeopardy of failing for that entire semester. With no prior notice.

This was put on the board's agenda as an emergency item. The school district did not know anything about it. The parents, there was no way to inform the parents. And the only, even if the parents had an excuse and the children had been there prior to Labor Day, if the parents would have—wrote a letter stating why that student was out of school, couldn't even take the word of the parents.

It had to come through Child Welfare and Attendance. We have asked the Attorney General for an opinion, but I cannot see how I as a parent, if I write an excuse for my child, it has to go to Child Welfare and Attendance, and they have to give the principal a reason why my child is out.

Chairman **Miller**. I will have to ask you to summarize so we can hear from the other witnesses.

Mrs. **LeGard**. One other thing, parental involvement. That disturbs me quite a bit, because I think lip service has been given to parental involvement, not only by the school district but by the Congress, also. You mandated parental involvement in Title 1. Parents brought credibility, plus the training the parents received through Chapter 1 or Title 1, were beneficial not only to the children but brought family and schools closer together.

So I would ask that you would consider asking to put that back into the Chapter 1 program. Parental involvement, although my school district has it, many do not. I thank you and apologize for having taken up more time than I should have but this is only the surface.

Thank you.

Chairman **Miller**. Thank you.

[Prepared statement of Eva LeGard follows:]

PREPARED STATEMENT OF EVA R. LEGARD, EAST BATON ROUGE PARISH SCHOOL BOARD, MEMBER; PUPIL SERVICES COMMITTEE, CHAIRPERSON; ADMINISTRATIVE SERVICES COMMITTEE, VICE-CHAIRPERSON; MANAGEMENT & PLANNING SERVICES COMMITTEE, MEMBER

CHILDREN, YOUTH AND FAMILIES IN THE SOUTHEASTERN REGION

Maturity is the art of living in peace with that which we cannot change, the courage to change that which can be changed and the wisdom to know the difference. I believe that we in the Southeastern Region can cope with the many issues facing us with help, Mr. Miller, coming from you and your Committee and the entire Congress. The theme "Children, Youth and Families in the Southeastern Region" is broad enough to cover many, many issues.

I have chosen to demonstrate the direct correlation of 1) curricula, 2) suspensions "push-outs" as I like to refer to most suspensions, 3) expulsions, 4) too many insensitive educators and teachers, 5) ignorance of School Board Policy and 6) too often only lip service to parental and community involvement to the importance of either a lack or availability of good and sound mental and physical health services, day care services and the lack of knowledge to deal with child abuse.

Curricula.—Inner city schools have traditionally received old, outdated books, instructional materials and supplies passed on from the affluent areas, which in many instances could not be of benefit to the college bound student. These ills were brought to public focus when schools were desegregated. However, parents had been echoing these facts all along. Every Tom, Dick and Harry has a pet project he wants to experiment on poor and minority students.

Suspensions (or "push-outs") expulsions.—It is evident that poor and minority students are suspended or expelled at the very least provocation. Affluent or non-minority students are warned and given verbal reprimands for many of the same offenses for which poor and minority students are suspended or expelled. The major reasons for the largest number of suspensions are tardiness and the missing of behavior clinics, some of which are as far as 22 miles from their assigned school without transportation service. In an October 11, 1983 suspensions/expulsions report releasing statistics for the first six weeks of 1983-84 school year, of 1,188 suspensions reported 82 percent were black as compared to 18 percent white; 21 expulsions reported 90 percent black again as compared to only 9 percent white. I might add that the total suspensions/expulsions statistics for the 1982-83 school year is reflective as same, with 73 percent suspensions black, 27 percent white and 86 percent of the expulsions black as compared to 14 percent white. There is a need for funds to implement programs that address suspension. (Note the new attendance laws as established by the LA State Board Department of Elementary and Secondary Education of August 1983). Suspensions/expulsions for 1982-83 school year totaled 15,362.

Insensitive educators and ignorance of school board policy.—What is sometimes referred to as educators not caring is really ignorance of the students culture and quite often ignorance of School Board Policy.

Lip service to parental and community involvement.—The Congress and local school districts have failed not only the Southeastern Region but the nation as well. You threw us a carrot in Chapter One (Title I) by mandating parental and community involvement and after saving hundreds of thousands and most likely millions of dollars for you and us taxpayers you snatched it back. We brought credibility to the program by demanding educational programs beneficial to students. We stopped practices which were not in keeping with the Regulations or Law, you seldom heard of audit exceptions, and more training provided the parents and community enabled them to monitor the Chapter I (Title I) program which benefitted not only our children but parents and community as well. The mandate eventually brought togetherness in many school districts where there was suspicion, accusations and down right hostility. An informed parent and community become allies.

Rights and responsibilities in academics, political and social world.—Too often the only time that the general public and parents are called upon and lengthy explanations given about the school district is when it is time to pass a tax elections. Our political, academic and social rights and responsibilities are then explained and the school districts share good and bad plight. The poor and the minority are the ones who pass tax elections. Therefore rights and responsibilities work both ways, it is up to the school district and Congress to keep us informed at regular intervals with what is happening to us and not at the crisis moment. Poor and minority parents have not had the kinds of impact they desire on local districts or the Congress. Hence, we have decided to form coalitions or educational and social reforms. What did Congress do—you have or you are saying to the poor no more—stop now. We are no longer going to allow Legal Services to handle many school related problems and certainy coalitions can in no way be supported. Finally, parents and the community were locked and fenced out and PTA practically driven out after desegregation.

As a result of desegregation many former Chapter I students are assigned to schools which are not eligible for Chapter I services. There is a need for the continuation of the ESAA funds to provide remedial activities through the follow the child phase of ESAA. There is a need for funds to implement supplementary activities in the area of human relations. Teachers and school administrators need in-service training in working with children and parents of a race different from their own.

Additional special education funding.—In many of the local schools, special education students are mainstreamed in various classes with regular students. There is a need for additional activities and/or programs to help eliminate problems created as a result of a lack of understanding of the needs of special education students by the regular students. The regular students must understand that there are different policies regarding discipline. There is a need for special safety measures. Not only should the regular students understand the needs of special students, but the parents of regular students must understand the special needs of these children in order to continue to give support to schools.

There is a shortage of teachers who are able to maintain a proper classroom setting with both regular children and special education children.

Vocational education.—Funding in this area has diminished over the years, when in fact the needs of society require a definite increase. With the cost of college education increasing, the availability of college education for many families is out of the realm of economic reason. That coupled with the fact that many blue collar and skilled labor areas of work have substantially increased their wages for workers put tremendous pressure upon school systems to provide courses and curriculum to prepare students for the job market, and increased funding would help to preserve dignity of productive and self-supporting citizens. That self-respect would make significant inroads toward more homogeneous communities.

Community education.—The amount of external support for community education also seems to have diminished over the past 10 years. In today's rapidly changing society the average individual will change vocations on the average of three to five times in their lifetime. With the rapid influx of new knowledge and information citizens eagerly respond to community education to keep them informed and to help them adjust to their changing lifestyles. And support in the area of community education should provide stable growth in a growing community.

Family support and day care centers.—Research studies have shown that family support center's intervention strategy can help stressed, dependent, isolated parents considered to be a high risk of abuse and neglect improve child rearing practices and learn to provide their children with the experiences and skills necessary for school success and eventual self-support. Studies have found that programs can reduce abuse and neglect, substantially reduce the need for costly out-of-home care and help to maintain and strengthen family life. It is also cost-effective.

Community health centers.—The Community Health Centers concept provide family-centered, comprehensive health services to low-income residents in facilities located as close as possible to the people who need care. These Community Health Centers operate on a full staff basis each weekday from 8:00 p.m. to 10:00 p.m. and from 8:00 a.m. to noon on Saturdays. Services available to the residents include medical, dental, health education, nutrition, pharmacy, x-ray and laboratory. Patient registration and treatment in the Health Centers Program are conducted on a total family basis. When one member of a family comes in for care, other members are registered and scheduled for appointments. The importance of preventive check-ups and immunization is emphasized, especially in the case of children. The Clinic chart for each family member is accompanied by information on the entire family.

Thus a Community Health Center's Social Worker consulted by the Public School about a child with learning problems has at hand results of the child's developmental screening tests as well as information about conditions in his home which might be influencing his behavior at school.

Besides health care, the neighborhood health program provides for many patients their first friendly link with the world outside the isolation of poverty. In their overwhelmingly favorable comments about the program, patients have indicated that they appreciate almost as much as the care itself the personal relationship possible with staff members. Said one patient "I have a feeling they care if you get well."

There are not many new ideas in health care but the Community Health Center is one. The concept borrows from the past, from the ideas of voluntary association and group practice and public responsibility for the indigent, but it is a new combination that makes a new whole.

Although Community Centers have come a long way, despite many frustrating obstacles and different hurdles, current economic and funding dilemmas suggest that the future portends no easier course.

In a time when significant minority seeks identification through militancy, the health center offers identification through participation. In a time when even the rich complain that care is fragmented, the Health Center offers comprehensive care. In a time when urban hospitals ponder flight or failure, the health care center offers meaningful ways to relate to a changed population.

"There was some concern at the outset of this program that, with its emphasis on ambulatory care, hospitals would not be friendly". This has been disproved by the enthusiasm of those who have participated." This has been a Godsend and a crisis need to be continued.

RECOMMENDATIONS

We must seriously consider whether or not the "back to basic" movement will jeopardize the full development of students. This is especially critical in the areas of art, music, and foreign languages. At the same time, we should not abandon high standards of achievement for students.

We must also consider whether or not the current focus on the achievement of minimum standards—a phenomenon prevelant in the Southeast—lowers our expectations and subsequently lowered student achievement.

Drug and alcohol abuse must continue to be a high priority. Priority should be given to finding opportunities for children to participate in organized activities directed by suitable role models. Education and awareness programs should be increased, and treatment programs continued.

A critical area in our efforts to reach a broad state of excellence in our schools is the relationship between parents and teachers and the school. Convenient opportunities for parents to feel more a part of the school need to be explored. The distance between parents and the schools must be decreased so that parents can shoulder more responsibility for sending a child who is ready and eager to learn. Joint programs in discipline should be encouraged with communication between parent and school.

Public schools will remain the central activity in the lives of most children for the next two decades. Educators, parents, communities, and businesses should form cooperative coalitions in every community to explore our attitudes and methods of shepherding our most valuable and precious resource and our hope for tomorrow.

We should direct our efforts to reaching children earlier and better. Many children come unprepared for the school experience. Materials and assistance should be made available to parents who wish it. These could be directed to parents as early as possible.

Finally, we need to take care that we do not create a "technology gap" in our schools by providing computers and other learning resources on an equitable basis. These resources must be distributed equitably in all school districts. There is a serious risk that only the wealthiest school districts and the brightest children will have access to this important tool, along with the smaller classes and increase in materials that often accompany them. Over the years, research has shown that youngsters in the Southern part of the United States consistently score lower on achievement tests than do their counterparts in the West, North or East.

A variety of resources are required to give the assistance needed to enable Southern youngsters to overcome these academic deficits. Unless these youngsters can acquire the necessary computational and communication skills to enter the nation's economic mainstream, we will find that it will cost even more to provide welfare or custodial care. Who can place a price tag on helping a disadvantaged youngster to realize his or her true potential and enable them to become productive citizens?

Overcoming the deficits of these youngsters requires a sustained and dedicated team effort from the parents, schools, communities, as well as local, state, and national political leaders. The bottom line is funding. Education must be the number one priority.

Education is not a national priority when a nation spends more to build and equip an aircraft carrier than it does to support education. Education is not a local or state priority when millions are spent on sports palaces and elaborate municipal complexes.

An adequate funding base must be found for public education. Remember that the supremacy of a nation in the field of technology is built on the skills of well-educated citizens. Remember that it does not matter how sophisticated are the military weapons in our arsenal. These are of no use if soldiers lack the education and technical ability to use and maintain them.

To provide the necessary human and financial resources to ensure the education of our youngsters is a costly endeavor. However, the cost of not doing so is even greater. We must ensure that America is recommitted to providing equal opportunity for all its citizens, whether they are rich, poor, black, white, red or brown.

Education and mental health go hand in hand. Recent research has shown one of the greatest assest each one of us can have is a feeling of competence. One of the best ways to create good mental health in our children thus is to create an environment in which they can succeed in mastering the skills and tasks of school. In a very real sense academic is the foundation stone of mental health.

A child who succeeds in learning feels competent and this in turn makes him feel good about himself. Feeling good about himself, he can and will tackle harder and more difficult material, which will enhance the learning process. Thus, we create an ever expanding upward spiral.

Conversely, the child who fails, and who feels inadequate will not achieve or even try those tasks which would lead to a positive self image. The downward spiral of failure, frustration, and defeat is produced.

Good mental health and good education are thus almost synonymous.

Each and every child needs: to believe they matter very much to someone, to believe that people care what happens to them, to believe that they belong—to a group or someplace, to feel that protective adults will be there in time of need, to know that they will not be harmed, to know that someone is there to help them, to feel that they are liked for themselves, just the way they are, to feel that they are accepted, to have a set of standards to live by, to have a belief in human values of kindness, courage, honesty, generosity and justice, to know that they will be encourage to try new things and to grow in a variety of dimensions, to know that someone has confidence in them and their ability, to have friendly help in learning how to behave toward people and things, to have adults around them who show them by EXAMPLE how to get along with others, to know that there are limits, to be able to accept their feelings but that they will not be allowed to hurt others, and to succeed in mastering themselves and their academic world.

A child who has learned is a adult who can cope. The cycle of poverty, deprivation, abuse and failure can be broken. Education is the instrument we can and must use to achieve this end. Truly, they need us today, we need them tomorrow.

In summary poor and minority parents, students and communities in the Southeastern Region have had to bear the brunt of inferior education, inadequate physical facilities, inferior materials, etc. When I refer to inferior education especially before desegration I am not referring to teachers. However, since desegregation predominately non-white school districts have gotten the inexperienced teachers. But we are told that is not by design and does not mean that these teachers are not good teachers. If this is true and is some cases it is, why not place one to three year teachers equally in affluenct, poverty or non-white areas.

I challenge all of you—parents—educators—local, state, and national leaders to unite in a common effort. That effort is a moral, financial, and political commitment to providing the youth of our nation with good, sound education.

And, finally I can emphasize the need and to support the recommendation of securing funds to implement programs that address suspensions and/or explusions.

Chairman MILLER. Mr. Pingree.

STATEMENT OF DAVID H. PINGREE, SECRETARY, DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES, FLA.

Mr. PINGREE. Mr. Chairman, members of the select committee, thank you for this opportunity to be with you today to discuss the challenges and opportunities facing the Nation's children, youth, and families.

In 1980 the Florida Legislature established within the department of health and rehabilitative services a children, youth, and families program. By consolidating a number of children's services, this State committed itself to a public policy which holds that the fundamental problems facing children, youth, and families are inseparable and intertwined—and that the solutions to these problems must incorporate an approach that addresses the full range of social and medical needs facing the whole family unit.

In addition, Gov. Bob Graham has made improved and expanded services to children and youth a top priority of his second term. He is committed to improving the quality of life for Florida's young people through an integrated, holistic approach to meeting the needs of the changing 20th century family.

During the time I have with you today, I would like to briefly outline some of the important successes Florida has attained relative to children and their families. Also, I would like to touch on some of the areas which I believe present us with the greatest challenges for the future.

The one essential element that is central to what we have accomplished, and what we hope to achieve, is prevention. We in Florida strongly believe that the quality of life we offer to the next generation of Floridians will be directly proportionate to the level of resources we devote to prevention services today.

As a point of departure, I will briefly describe the organization and structure of the Florida Department of Health and Rehabilitative Services. The department provides a wide range of health and social services to the citizens of Florida through a decentralized, integrated service delivery system. What this means is that we administer nearly all of the State's human services programs through one agency, organized at the local level into 11 service districts.

Medical services for children, training for developmentally disabled, public health programs, mental health services, economic assistance, services to our elderly population, and many others are delivered in local communities under the overall direction of one administrator. This unique structure provides our 35,000 employees the framework for addressing the multiple problems often confronting a single family or individual in need.

This structure is especially suited to providing services to children. And, it is particularly valuable to our emphasis on prevention services.

An excellent example is Florida's regional perinatal intensive care program. I understand Dr. Shiebler is unable to be here today, but he is the father of this program. This model program, established in 1974, provides medical care to women with high risk pregnancies and to sick and/or low birth weight newborns. Through a network of 10 highly specialized intensive care centers, Florida has provided intensive neonatal care to more than 34,000 newborns since this program began. This year the program will spend $24.5 million providing prenatal and obstetrical services to women at risk of having a sick or low birth weight baby and providing intensive medical care of neonates.

The program includes a 24-hour toll free telephone line, called the CARE line, enabling physicians from throughout the State to find the nearest available placement for a patient in need. We are particularly pleased with the expansion of the program in 1982 to include what is called stepdown. This element of the program provides less costly, yet still very specialized care, to neonates who have graduated from the intensive care units. Not only is this measure cost saving, but it also provides an essential form of followup care that can have an effect on the infant's long-term health and development, while at the same time freeing up beds for other low weight newborns.

We believe that the program has had a significant impact on Florida's infant mortality rate, which has dropped since 1972 from 14.2 deaths per 1,000 live births, to 10.3 per 1,000 in 1982, which is well below the Nation's rate of 11.7 deaths per 1,000 births.

We recognize in our emphasis on prevention programs that initiatives for children and youth—whether they be to prevent handicapping conditions or to reduce the level of delinquency—must strike at the health and societal factors inherent in the lifestyles of families at risk.

In 1982 the department, under the direction of the State health officer, established a Maternal and Infant Health Care Task Force. This group was charged with advising the State on problems and priorities that must be addressed to improve access and availability to maternity and infant care.

After a year-long study, this group developed a series of recommendations aimed at improving maternal and child health with a major emphasis on prevention.

The task force found that in spite of the provision of services affecting maternal and child health—for example, our participation in the WIC program—10,000 low birth weight babies were born in Florida last year.

The task force concluded that maternal and child health problems cannot be addressed in isolation. Increased medicaid services, expanded transportation services, and supplemental food and nutrition programs are also needed. I have provided your staff with that particular report. If you like, that can be read into the record.

Perhaps one of the most poignant issues facing children, youth, and families is the tragic and vicious cycle of child abuse, where the abused child often eventually becomes the abusive parent. Florida has established 14 multidisciplinary child abuse teams that, we believe, offer an exemplary standard and a model approach to addressing the problem. These teams are composed of medical experts, psychologists, social workers, and other professionals skilled at providing treatment to the abused child and intervention services to the family. Last year, these teams served 17,300 children. Most important, they worked with the children's families trying to get at the causes of abuse.

During the past 3 years the dramatic influx of Haitian, Cuban, and other refugees and entrants has had an enormous impact on this State's need to provide a diversity of health and human services for children, youth, and families.

Since 1980, more than 160,000 Cuban and Haitian immigrants have arrived in Florida. Since approximately 90 percent of these entrants settled in the State, Florida's population increased a full percentage point just as a result of the massive immigrations.

The arrival of the Caribbean immigrants placed an immediate demand on nearly every service provided by the State of Florida—ranging from prenatal care to education to employment services.

The unreimbursed costs to State and local governments has been calculated to be almost $200 million; the exact costs are probably incalculable.

For example, Jackson Memorial Hospital, located here in Miami, estimates that it is currently spending $1 million each month serving the refugee and entrant population in this county. A significant portion of this will be spent on obstetrical services. Yet for Federal fiscal year 1983, the hospital will only be allocated $7.1 million of Federal targeted assistance for health care. The total allocation to Florida to provide health care services to this population this year is $8.9 million—50 percent less than we received from the Federal Government last year.

There are currently 19,000 refugees and entrants in grades K-12 in Florida public schools. We estimate that State and local governments have incurred a staggering $112 million in costs above those reimbursed by the Federal Government in providing K-12 education for refugees and entrants.

Another population presenting a special challenge in the provision of health and social services is the large number of migrant workers for whom Florida is a home base.

We estimate that more than 200,000 migrants arrive in Florida between October and May of each year. With an average family size of 4.7 people, we are barely scratching the surface of need presented by this mobile population. The greatest need is day care.

The Redlands Christian Migrant Association, which operates 32 day care centers to serve 2,500 children has a waiting list of more than 800 migrant children who were brought in by their parents yet turned away because no space was available.

Florida's migrant child education program is among the largest in the Nation. Last year, it served about 5,800 migrant children in grades K-12. In addition, the State has provided $2.5 million for preschool education for migrant children. Although we have made great strides in serving Florida's families and children we still face many challenges.

Just recently Governor Graham took another important step in that direction by appointing the Constituency for Children. This group, comprised of concerned citizens from the private and public sectors, is currently in its formative stage. Spearheaded by the efforts of Circuit Judge William E. Gladstone, one of Miami's strongest child advocates, the group will work with grassroots child advocacy groups across the State to address the unmet needs of Florida's children in the areas of education, substance abuse, juvenile justice, and social services. The aim is to develop a statewide constituency that can work outside of the traditional program and bureaucratic structure but with the singular goal of improving the lives of the State's children.

By the way, this is not a heavily funded program. It is funded with an $80,000 State appropriation. These are citizen participants and volunteers who are concerned about the welfare of children in the State. The challenges facing us in providing for children, youth, and families must be addressed through partnerships, public and private, State and local, education and human services, professional and volunteer.

The fact that the Select Committee on Children, Youth and Families is here in Miami, and is holding similar meetings elsewhere we hope is a signal of a national recognition of the need for an additional partnership on behalf of children and youth—a Federal/State partnership leading to a national constituency with a network of 50 State organizations similar to the one being established in Florida.

We strongly feel that a national policy on children, youth, and families is essential and hope that this select committee will serve as the catalyst for the development, adoption, and implementation of such a policy. The Nation's future does rest with its children. Therefore, they warrant priority attention. We in Florida are desirous of working with you to forge a national policy framework which will provide future generations of children with both hope and opportunity for a healthier and generally better environment.

When I was a college student, I was a delegate to the White House Conference on Children and Youth in 1960. Today in 1983 we are talking about some of the same problems, I think the time has come for us to really sit down and address these issues and stop talking about them.

Chairman MILLER. Thank you.

[Prepared statement of David Pingree follows:]

PREPARED STATEMENT OF DAVID H. PINGREE, SECRETARY, DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES, STATE OF FLORIDA

Mr. Chairman, members of the Select Committee on Children, Youth and Families. Thank you for this opportunity to be with you today to discuss the challenges and opportunities facing the nation's children, youth and families.

In 1980 the Florida Legislature established within the Department of Health and Rehabilitative Services a Children, Youth and Families Program. By consolidating a number of children's services, this state committed itself to a public policy which holds that the fundamental problems facing children, youth and families are inseparable and intertwined—and that the solutions to these problems must incorporate an approach that addresses the full range of social and medical needs facing the whole family unit.

In addition, Governor Bob Graham has made improved and expanded services to children and youth a top priority of his second term. He is committed to improving the quality of life for Florida's young people through an integrated, holistic approach to meeting the needs of the changing 20th century family.

During the time I have with you today, I would like to briefly outline some of the important successes Florida has attained relative to children and their families. Also, I would like to touch on some of the areas which I believe present us with the greatest challenges for the future.

The one essential element that is central to what we have accomplished, and what we hope to achieve, is prevention. We in Florida strongly believe that the quality of life we offer to the next generation of Floridians will be directly proportionate to the level of resources we devote to prevention services today.

As a point of departure, I will briefly describe the organization and structure of the Florida Department of Health and Rehabilitative Services. The Department provides a wide range of health and social services to the citizens of Florida through a decentralized, integrated service delivery system. What this means is that we administer nearly all of the state's human services programs through one agency, organized at the local level into eleven service districts.

Medical services for children, training for developmentally disabled, public health programs, mental health services, economic assistance, services to our elderly population, and many others are delivered in local communities under the overall direction of one administrator. This unique structure provides our 35,000 employees the framework for addressing the multiple problems often confronting a single family or individual in need.

This structure is especially suited to providing services to children. And, it is particularly valuable to our emphasis on prevention services.

An excellent example is Florida's Regional Perinatal Intensive Care Program. This model program, established in 1974, provides medical care to women with high risk pregnancies and to sick and/or low birth weight newborns. Through a network of 10 highly specialized intensive care centers, Florida has provided intensive neonatal care to more than 34,000 newborns since this program began. This year the program will spend $24.5 million providing prenatal and obstetrical services to women at risk of having a sick or low birth weight baby and providing intensive medical care to neonates.

The program includes a 24-hour toll free telephone line, called the CARE line, enabling physicians from throughout the state to find the nearest available placement for a patient in need. We are particularly pleased with the expansion of the program in 1982 to include what is called "step-down." This element of the program provides less costly, yet still very specialized care, to neonates who have "graduated" from the intensive care units. Not only is this measure cost-saving, but it also provides an essential form of follow-up care that can have an effect on the infant's long-term health and development, while at the same time freeing up beds for other low weight newborns.

The Regional Perinatal Intensive Care Program is one of the most important prevention programs in existence in Florida. It provides us with the ability for medical intervention when women are at risk with a problem pregnancy, and it provides us with the facilities to give comprehensive care to newborns. We believe that the program has had a significant impact on Florida's infant mortality rate, which has dropped since 1972 from 14.2 deaths per 1,000 live births, to 10.3 per 1,000 in 1982, which is well below the nation's rate of 11.7 deaths per 1,000 births.

We recognize in our emphasis on prevention programs that initiatives for children and youth—whether they be to prevent handicapping conditions or to reduce the level of delinquency—must strike at the health and societal factors inherent in the lifestyles of families at risk.

In 1982 the Department, under the direction of the state health officer, established a Maternal and Infant Health Care Task Force. This group was charged with advising the state on problems and priorities that must be addressed to improve access and availability to maternity and infant care.

After a year-long study, this group developed a series of recommendations aimed at improving maternal and child health with a major emphasis on prevention.

The task force found that in spite of the provision of services affecting maternal and child health—for example, our participation in the WIC (Women, Infants and Children) program—10,000 low birth weight babies were born in Florida last year.

The task force concluded that maternal and child health problems cannot be addressed in isolation. Increased Medicaid services, expanded transportation services, and supplemental food and nutrition programs are also needed.

Perhaps one of the most poignant issues facing children, youth and families is the tragic and vicious cycle of child abuse, where the abused child often eventually becomes the abusive parent. Florida has established 14 multi-disciplinary child abuse teams that, we believe, offer an exemplary standard and a model approach to addressing the problem. These teams are composed of medical experts, psychologists, social workers and other professionals skilled at providing treatment to the abused child and intervention services to the family. Last year, these teams served 17,300 children. Most important, they worked with the children's families trying to get at the causes of abuse.

Yet, even with the important strides made by the Child Abuse Protection Teams, we are not even close to meeting the needs. Last year in Florida, more than 91,000 children were reported abused or neglected. While approximately 50 percent of these reports were confirmed, we realized that at the very least, more than half of all child abuse and neglect goes unreported.

In addition to an innovative service delivery system, Florida has unique circumstances and populations. During the past three years the dramatic influx of Haitian, Cuban and other refugees and entrants has had an enormous impact on this state's need to provide a diversity of health and human services for children, youth and families.

Since 1980, more than 160,000 Cuban and Haitian immigrants have arrived in Florida. Since approximately 90 percent of these entrants settled in the state, Florida's population increased a full percentage point just as a result of the massive immigrations.

The arrival of the Caribbean immigrants placed an immediate demand on nearly every service provided by the state of Florida—ranging from prenatal care to education to employment services.

The unreimbursed costs to state and local governments has been calculated to be almost $200 million; the exact costs are probably incalculable.

For example, Jackson Memorial Hospital, located here in Miami, estimates that it is currently spending one million dollars each month serving the refugee and entrant population in this country. A significant portion of this will be spent on obstetrical services. Yet for federal fiscal year 1983, the hospital will only be allocated $7.1 million of federal Targeted Assistance for health care. The total allocation to Florida to provide health care services to this population this year is $8.9 million—50 percent less than we received from the federal government last year.

There are currently 19,000 refugees and entrants in grades K-12 in Florida public schools. We estimate that state and local governments have incurred a staggering $112 million in costs above those reimbursed by the federal government in providing K-12 education for refugees and entrants.

We have been adamant in our demands that this is a federal responsibility. Our cries for full reimbursement for services provided to refugee children and families have fallen on deaf ears.

While the refugee crisis has fallen from the headlines—the demands on our systems from this population continue to grow. Immigrants and refugee require many of the same basic services needed by our population at large—employment services, health care, mental health services and social services. In many areas the level of need is a great deal higher as a result of the stresses of assimilation and the handicaps of a language barrier.

Yet, as this issue continues to fade from public attention, the level of federal support shrinks. This is particularly troublesome in light of the realization that the young people who have come to our shores from other countries will only be afforded the fruits of our society—the health and well-being sought for them by their parents—if we provide the support services they now require.

Another population presenting a special challenge in the provision of health and social services is the large number of migrant workers for whom Florida is a home base.

We estimate that more than 200,000 migrants arrive in Florida between October and May of each year. With an average family size of 4.7 people, we are barely scratching the surface of need presented by this mobile population.

We continue to lack adequate funds for the acute medical care needs of migrant workers. There continues to be insufficient housing. Child care resources continue to be inadequate. The Redlands Christian Migrant Association, which operates 32 day care centers to serve 2,500 children has a waiting list of more than 800 migrant children who were brought in by their parents yet turned away because no space was available.

Florida's Migrant Child Education Program is among the largest in the nation. Last year, it served about 5,800 migrant children in grades K-12. In addition, the state has provided $2.5 million for preschool education for migrant children.

Despite these efforts, we have found that there is about an 80 percent school dropout rate for migrant children. One study has shown that out of 100 migrant children entering first grade this year, only two will graduate from high school. These statistics are obvious indicators that we have been unsuccessful in significantly reducing the prospect of continuing poverty for migrant families in this country.

We have made some strides in serving Florida's families and children—and we face many challenges for the future.

We continue to work toward improving the reach of our service delivery system—with particular emphasis on prevention—and on establishing those that can work on behalf of Florida's young people.

Just recently Governor Graham took another important step in that direction by appointing the Constituency for Children. This group, comprised of concerned citizens from the private and public sectors, is currently in its formative stage. Spearheaded by the efforts of Circuit Judge William E. Gladstone, one of Miami's strongest child advocates, the group will work with grassroots child advocacy groups across the state to address the unmet needs of Florida's children in the areas of education, substance abuse, juvenile justice and social services. The aim is to develop statewide constitutency that can work outside of the traditional program and bureaucratic structure but with the singular goal of improving the lives of the state's children.

Establishing this group reaffirmed Florida's commitment to pool whatever resources are available from whatever source in order to better serve our young people. At the same time, it is also a recognition that the challenges meeting us in providing for children, youth and families must be addressed through partnerships—public and private, state and local, education and human services, professional and volunteer.

The fact that the Select Committee on Children, Youth and Families is here and is holding similar meetings elsewhere we hope is a signal of a national recognition of the need for an additional partnership on behalf of children and youth—a federal/state partnership leading to a national constituency with a network of 50 state organizations similar to the one being established in Flordia. We strongly feel that a national policy on children, youth and family is essential and hope that this Select Committee will serve as the catalyst for the development, adoption and implementation of such a policy. The nation's future does rest with its children. Therefore, they warrant priority attention. We in Florida are desirous of working with you to forge a national policy framework which will provide future generations of children with both hope and opportunity for a healthier and generally better environment.

1983-84 Approved Budget (as of 9/30/83)

Office of the Secretary	$3,245,092
Assistant Secretary for Administrative Services	30,265,979
Assistant Secretary for Program Planning	36,381,829
Assistant Secretary for Operations	64,519,331
District Administration	38,700,447
Children's Medical Services	66,691,434
Aging and Adult Services	95,634,107
Children and Youth Institutions	13,066,041
Children, Youth and Families Services	207,059,711
Mental Health Institutions	142,681,019
Alcohol, Drug Abuse and Mental Health	121,869,511
Developmental Services Institutions	86,277,918
Developmental Services	134,841,210
Vocational Rehabilitation	42,419,530
Economic Services	420,119,973
Health Services (includes CHUs)	232,085,057
T.B. Hospital	5,692,492
Medicaid	878,660,030
Total	2,620,210,711

CYF Budget Allocation by Program Component Fiscal Year 1983-84

Community Mental Health Services Community Drug Abuse Services: Residential and Non-Residential Services for Emotionally Disturbed Children and Youth including Wilderness Therapeutic Care, Therapeutic Foster Homes, Therapeutic Group Homes	18,158,673
Detention Services Secure and Non-Secure Detention; Client Transportation	20,424,207
Intake and Assessment Single Intake (for Delinquency and Dependency); Emergency Shelters; Runaway Shelters; Crisis Homes; Transportation of Runaways	23,039,408
Child Day Care/Case Management and Related Services for Families and Dependent Youth Child Day Care; Specialized Family Services; Intensive Crisis Counseling; Housekeeping Services; Local Services Programs; Individual and Family Counseling; Parent Education Training; Protective Services; Services to Status Offenders	57,285,945
Non-Residential Services for Delinquent Youth Community Control and Furlough; Special Intensive Groups; Intensive Crisis Counseling; TRY Centers; Associated Marine Institutes; Juvenile Alternative Services Program; Operation Involvement; Project CREST; Intensive Learning Alternative Program	16,077,672

Residential Services for Delinquent Youth	10,237,833
STOP Camps; START Centers; Halfway Houses; Group Treatment Homes; Project STEP; Florida Keys Marine Institute; Pinellas Youth Home; Family Group Homes; San Antonio Boys Village; Serious Offender Pilot Program	
Placement/Supervision for Children	35,311,773
Foster Care; Residential Group Care; Adoption Services; Maintenance and Medical Adoption Subsidies; Purchase of Adoption Services	
District Program Management and Supervision	5,135,959
Children and Youth Institutions	12,853,072
Dozier School for Boys in Marianna; Alyce D. McPherson School in Ocala; Florida School for Boys at Okeechobee	
TOTAL BUDGET	$ 198,524,542

State of Florida
Department of Health and Rehabilitative Services

Fact Sheet

WHAT IS HRS?

It's people helping people. The Department of Health and Rehabilitative Services is the agency that runs virtually all of the state-sponsored health and social service programs. It's 35,486 employees, plus a large number of private industry workers paid by HRS, providing aid to people who are socially, economically, or physically deprived. But it's more than a "welfare agency." HRS protects Floridians from disease and educates the public on how to stay healthy. It's human services...one-to-one...with the final product being a healthier, happier individual.

WHOM DOES HRS SERVE?

HRS serves every person in the state. Every time people drink a glass of water or eat in a restaurant, they have been served by HRS public health programs. In addition, HRS has specialized programs for the poor, the disabled, the elderly, the young and the mentally ill.

HOW MUCH DOES IT COST?

The current annual HRS operating budget is $2.274 billion, which accounts for about one-fifth of the state's budget. About 49 percent of that comes from federal tax dollars. The rest comes from the state.

WHO RUNS HRS?

The Governor appoints the Secretary, chief administrative officer of HRS. The Secretary appoints three assistant secretaries: one is in charge of planning and monitoring programs, one is in charge of carrying out those programs (operations), and the other is in charge of administrative services, such as financial and personnel matters. The Secretary also appoints 11 district administrators, who are accountable for delivering services at the local level.

WHAT SERVICES DOES HRS OFFER?

The complete list of services offered by HRS is a lengthy one. However, most of the services fall under one of the following nine programs areas:

- Aging and Adult Services
- Children's Medical Services
- Children, Youth and Families
- Developmental Services
- Economic Services
- Health
- Medicaid
- Mental Health
- Vocational Rehabilitation

In addition to these program areas, HRS is responsible for operating various facilities, such as mental health institutions, Sunland centers for retarded citizens, a tuberculosis hospital, alcoholic rehabilitation clinics, youth detention centers and training schools.

HRS works in conjunction with counties in the operation of county health departments, with hospitals in the operation of Children's Medical Services clinics, and with non-profit volunteer groups in the operation of vocational rehabilitation facilities.

HRS also undertakes many regulatory functions such as licensing and overseeing hospitals, health facilities and laboratories, and licensing many health professionals and paraprofessionals such as X-ray technicians and emergency medical personnel. Construction and additions to health facilities are overseen by the health planning section of HRS. Vital records and public health statistics are gathered and analyzed by HRS.

HOW IS HRS ORGANIZED?

The 1975 Reorganization Act placed virtually all the state's health and social service agencies under HRS. Prior to that time, the various program activities were carried out by separate divisions, such as the Division of Youth Services. Legislators decided it was best to place these services under one roof, where a person could walk in and receive several services, rather than having to go to different locations in town. Legislators also decided it was best to run these service centers in the local community, rather than try to run them from Tallahassee. Thus the state

DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES
1982-83 ESTIMATED EXPENDITURES
AUGUST 31, 1982

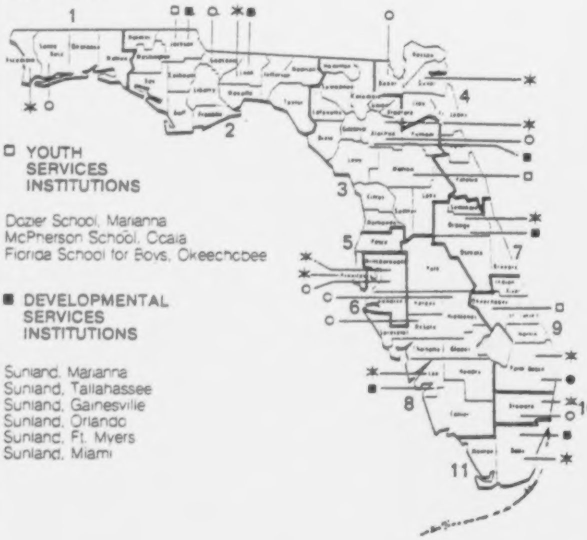
Budget Entity	Total
Office of the Secretary	$ 2,554,183
Assistant Secretary for Administrative Services	30,658,369
Assistant Secretary for Program Planning & Development	34,044,865
Assistant Secretary for Operations	55,911,574
District Administration	38,816,821
Children's Medical Services	64,010,247
Aging and Adult Services	95,004,275
Children, Youth and Family Services	182,673,437
Children & Youth Institutions	11,995,546
Alcohol, Drug Abuse & Mental Health Services	116,277,047
Mental Health Institutions	129,991,630
Developmental Services	109,000,429
Developmental Services Institutions	94,286,694
Vocational Rehabilitation	36,813,109
Economic Services	375,971,635
Health Services	169,475,217
T.B. Hospital	5,614,516
Medicaid Services	712,968,884
TOTAL	$ 2,274,710,288

was divided into 11 districts. Each district has a district administrator, who runs a "mini-HRS" at the local level. They carry out programs to fit the needs of their geographical areas.

The administrative and program planning and evaluation functions of the department are still carried out in Tallahassee. Each program area has a program director who heads up the planning and evaluation efforts.

In addition, the legislature set up state and district advisory councils. These allows citizens a chance to participate in the department's decision-making process. State and district human rights advocacy committees were established to protect the constitutional and human rights of clients. Members of both groups are appointed by the Governor.

HRS District Boundaries



○ MENTAL HEALTH INSTITUTIONS

Florida State Hospital, Chattahoochee
North Florida Evaluation and Treatment Center, Gainesville
Northeast Florida State Hospital, Macclenny
G. Pierce Wood Memorial Hospital, Arcadia
South Florida State Hospital, Pembroke Pines
Florida Alcohol Treatment and Research Center, Avon Park
Florida Mental Health Institute, Tampa
Santa Rosa Geriatric Residential Treatment Center, Milton

● TUBERCULOSIS HOSPITAL

A.G. Holley State Hospital, Lantana

✱ HRS DISTRICT HEADQUARTERS

□ YOUTH SERVICES INSTITUTIONS

Dozier School, Marianna
McPherson School, Ocala
Florida School for Boys, Okeechobee

■ DEVELOPMENTAL SERVICES INSTITUTIONS

Sunland, Marianna
Sunland, Tallahassee
Sunland, Gainesville
Sunland, Orlando
Sunland, Ft. Myers
Sunland, Miami

DEPARTMENTAL GOALS

Client Services

1. To promote client independence through employment training, support services, and improved benefits to those in greatest need.
2. To improve services to the elderly. Specifically:
    - a. To expand and improve Community Care for the Elderly (CCE).
    - b. To upgrade nursing home services and to protect patient welfare through strict enforcement of nursing home standards relating both to care and operations.
3. To develop a range of essential services to meet the special needs of children, youth, and families.
4. To limit the use of state institutions by developing alternative programs for persons able to live in the community, while at the same time improving the quality of care and treatment for clients remaining in institutions.
5. To strengthen the health care system by providing greater access to basic health care through a partnership between the department, the private health care community, and local public health programs.
6. To focus on preventive services in all HRS programs, with a specific emphasis on maternal and child health, perinatal care, early intervention, and programs to prevent or reduce substance abuse and physical / emotional abuse.
7. To continue working with the federal and local governments, as well as voluntary agencies, to address the health, housing, employment, social services and resettlement needs of Caribbean and other refugees.

Administration

8. To improve HRS administration and operations. Specifically:
    - a. To reduce fraud and abuse in the AFDC, Food Stamp, and Medicaid programs.
    - b. To contract for services where it is more cost-efficient and cost-effective and to provide adequate monitoring of these contracted services.
    - c. To increase employee morale and productivity.
    - d. To reduce paperwork and consolidate agency forms.
    - e. To maintain and improve affirmative action efforts.
    - f. To maintain and improve fiscal forecasting and control systems.
9. To complete the development and implementation of the department's major information systems, with special emphasis on the Client Information System.
10. To improve working relationships with other state agencies, units of local government, and community organizations, in order to maximize resources.

HRS SECRETARIES

James A. Bax	July 1969 - April 1971
Emmett S. Roberts	June 1971 - July 1973
O.J. Keller	August 1973 - May 1975
Emmett S. Roberts	May 1975 - August 1975
William J. Page	August 1975 - September 1978
Emmett S. Roberts	October 1978 - January 1979
David H. Pingree	January 1979 - June 1980
Alvin J. Taylor	July 1980 - October 1981
David H. Pingree	October 1981 - Present

HRS PROGRAMS

A Summary

Aging And Adult Services

Information and Referral
Abuse Prevention Services
Senior Activity Centers
Meals Programs
Home Health Care and Other In-Home Services
Placement Services
Community Care for the Elderly
Displaced Homemaker Services
Transportation
Adult Day Care
Counseling and Other Support Services

Alcohol, Drug Abuse and Mental Health

Emergency Counseling
Inpatient
Hospitals — Long and Short-Term Care
Outpatient
Counseling
Partial Hospitalization
Day / Night Care
Consultation and Education
Screening Assistance to Courts
Halfway Houses
Follow-up Care for Discharged Mental Patients
Specialized Services for Children and Elderly

Alcohol Abuse
Detoxification
Evaluation
Residential Services
Day / Night Care and Treatment
Outpatient Services
Treatment
Counseling
Rehabilitation
Halfway Houses
Court and Law Enforcement Liaison Services
Employee Assistance Programs
Community Consultation, Education and Prevention Programs
Drug Abuse
Community Treatment and Prevention Centers
Detoxification
Placement for Treatment
Group and Individual Counseling
Abuse Prevention Programs-Schools
Halfway Houses
Residential Treatment
Methadone Maintenance
Medical and Dental Assistance
Job Placement

Children's Medical Services

Clinics
Pediatric
Specialty
Referral Centers
Regional Programs
Renal
Diabetes
Genetics
Perinatal
Spinal Cord Injury
Special Statewide Programs
Infant Screening
Child Abuse
Rheumatic Fever

Children, Youth and Families

Dependency / Delinquency Intake
Prevention and diversion services
Specialized family services
Protective services for children
Crisis homes and emergency shelter care
Child day care services
Detention (secure and non-secure)
Commitment programs for delinquent youth
Residential centers and programs
Non-residential programs
Community control and furlough
Mental health services
Adoption and related services
Foster care

Developmental Services

Evaluation
Family Counseling
Home Care / Equipment Assistance
Group and Foster Homes
Community Facilities
Intermediate Care Facilities for Mentally Retarded
Cluster Facilities
Residential Care - Sunland Centers
Training and Education Programs
Vocational Training
Medical Care
Transportation
Counseling
Day Care

Economic Services

Aid to Families with Dependent Children
Food Stamps
Refugee Assistance Program
Low-Income Energy Assistance Program
Disaster Relief
Supported Work Assistance Program and Work Incentive Program

Health

Personal Health
Non-Communicable Disease Services
Cardiovascular Disease Services
Hypertension Services
Diabetes Services
Cancer Services
Nursing Care at Home Services
Non-Communicable Disease Surveillance / Investigations
Socio-Behavioral Services
Health-Risk Reduction Services
Nutrition Health Services
Women / Infants / Children Supplemental Food Program
Family Planning Services
Maternal Health Services
MIC Projects: Maternal
Lay Midwifes
Infant / Child / Adolescent Health Services
Children and Youth Project
MIC Projects: Infants
EPSDT Services
School Health Services
Special Surveillance
Adult Health Services
Dental Health Services
General Personal Health Services
Communicable Disease
Communicable Disease Control Services
Immunization Services
Venereal Disease Services
Tuberculosis Control Services
Communicable Disease Surveillance / Investigations
General Public Health
Vital Statistics Services
Vital Records Disposition, Certification and Compliance Services
Environmental Health
Consumer Safety
Occupation Health Services
Consumer Product Safety
Emergency Medical Services
Food Hygiene Services
Housing Public Facilities and Conveyance Services
Group Care Facilities Services
Housing and Public Building Safety and Sanitation Services
Trailer Park and Camps Services
Common Carrier Sanitation Services
Water and Waste Services
Private Water System Services
Public Drinking Water Services
Bottled Water Services
Swimming Pool and Bathing Places Services
Individual Sewage Disposal Services
Public Sewage Services
Solid Waste Disposal Services
Environmental Surveillance / Control Services
Sanitary Nuisance Services
Rabies Surveillance / Control Services
Arbovirus Surveillance Services
Rodent Control Services
Arthropod Control Services
Water Pollution Services
Air Pollution Services
Radiological Health Services
Toxic Substances-Hazardous Materials Services
General Environmental Health Services

6

Health Planning And Development

- **Comprehensive Health Planning**
  - Statewide Health Planning Coordination
  - Planning, Research and Development
- **Community Medical Facilities**
  - Architectual and Engineering
  - Development and Monitoring
  - Regulatory Review and Planning
- **Cooperative Health Statistics**

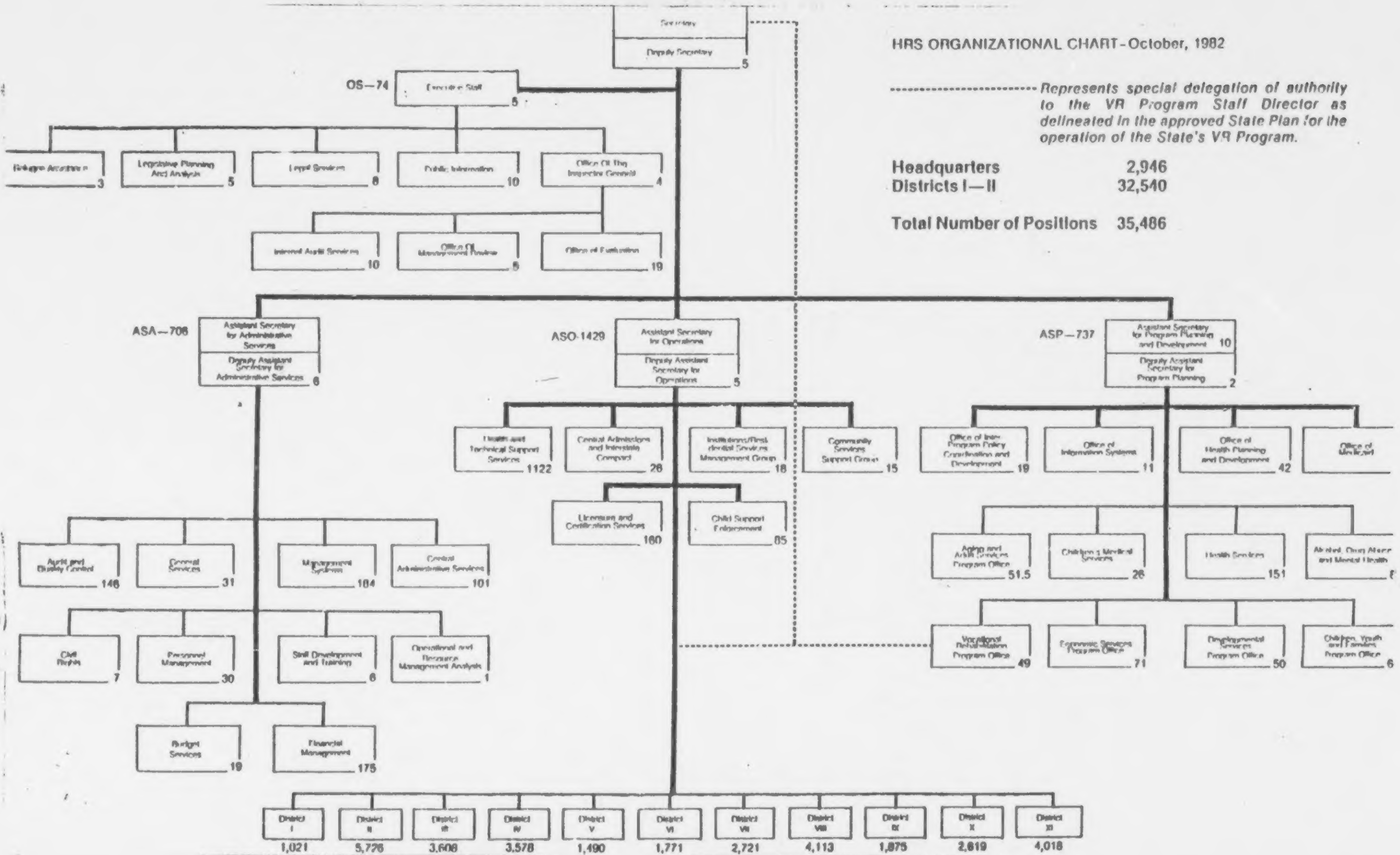
Medicaid

- Nursing Home Care
- Pharmaceutical Support
- Medical Care
  - Inpatient
  - Outpatient

Vocational Rehabilitation

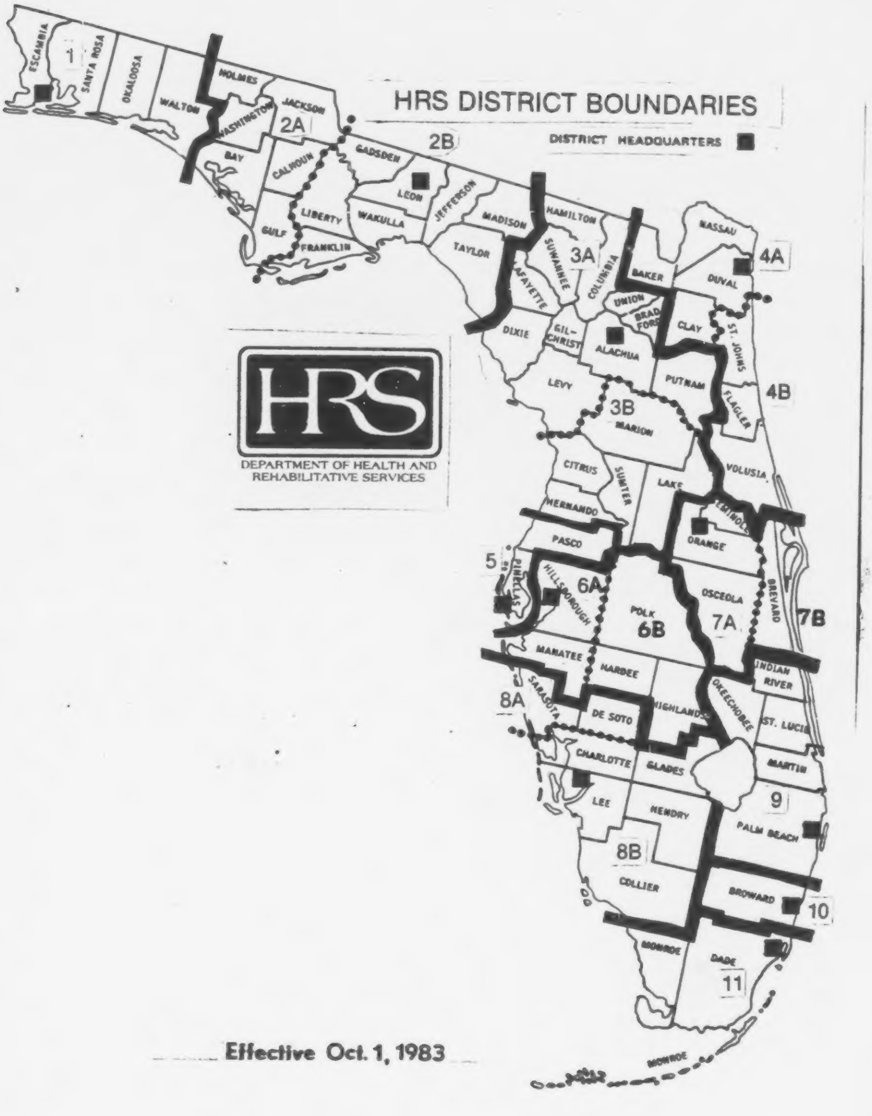
- Medical Evaluation
- Vocational Adjustment
- Treatment
- Hospitalization
- Counseling and Guidance
- Artifical Limbs and Appliances
- Equipment for Jobs
- Fiancial Assistance while in Rehabilitation Programs
- Job Placement
- Transportation
- Post Employment Services

HRS ORGANIZATIONAL CHART-October, 1982


Secretary
Deputy Secretary 5
OS—74
Executive Staff 5
Refugee Assistance 3
Legislative Planning And Analysis 5
Legal Services 8
Public Information 10
Office Of The Inspector General 4
Internal Audit Services 10
Office Of Management Review 5
Office of Evaluation 19
ASA—706
Assistant Secretary for Administrative Services
Deputy Assistant Secretary for Administrative Services 6
Audit and Quality Control 146
General Services 31
Management Systems 104
Central Administrative Services 101
Civil Rights 7
Personnel Management 30
Staff Development and Training 6
Operational and Resource Management Analysis 1
Budget Services 19
Financial Management 175
ASO-1429
Assistant Secretary for Operations
Deputy Assistant Secretary for Operations 5
Health and Technical Support Services 1122
Central Admissions and Interstate Compact 26
Institutions/Residential Services Management Group 18
Community Services Support Group 15
Licensure and Certification Services 160
Child Support Enforcement 05
ASP—737
Assistant Secretary for Program Planning and Development 10
Deputy Assistant Secretary for Program Planning 2
Office of Inter-Program Policy Coordination and Development 19
Office of Information Systems 11
Office of Health Planning and Development 42
Office of Medicaid
Aging and Adult Services Program Office 51.5
Children's Medical Services 26
Health Services 151
Alcohol, Drug Abuse and Mental Health
Vocational Rehabilitation Program Office 49
Economic Services Program Office 71
Developmental Services Program Office 50
Children, Youth and Families Program Office 6
District I 1,021
District II 5,726
District III 3,608
District IV 3,578
District V 1,490
District VI 1,771
District VII 2,721
District VIII 4,113
District IX 1,875
District X 2,619
District XI 4,018

-------------------- *Represents special delegation of authority to the VR Program Staff Director as delineated in the approved State Plan for the operation of the State's VR Program.*

Headquarters	2,946
Districts I—II	32,540
Total Number of Positions	35,486


HRS DISTRICT BOUNDARIES
DISTRICT HEADQUARTERS ■
HRS
DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES
1
2A
2B
3A
3B
4A
4B
5
6A
6B
7A
7B
8A
8B
9
10
11
ESCAMBIA
SANTA ROSA
OKALOOSA
WALTON
HOLMES
WASHINGTON
JACKSON
BAY
CALHOUN
GULF
LIBERTY
FRANKLIN
GADSDEN
LEON
WAKULLA
JEFFERSON
MADISON
TAYLOR
HAMILTON
LAFAYETTE
SUWANNEE
COLUMBIA
BAKER
NASSAU
DUVAL
UNION
BRADFORD
CLAY
ST. JOHNS
DIXIE
GILCHRIST
ALACHUA
PUTNAM
FLAGLER
LEVY
MARION
CITRUS
SUMTER
LAKE
VOLUSIA
HERNANDO
SEMINOLE
ORANGE
PASCO
PINELLAS
HILLSBOROUGH
POLK
OSCEOLA
BREVARD
MANATEE
HARDEE
INDIAN RIVER
SARASOTA
DE SOTO
HIGHLANDS
OKEECHOBEE
ST. LUCIE
CHARLOTTE
GLADES
MARTIN
LEE
HENDRY
PALM BEACH
COLLIER
BROWARD
MONROE
DADE
MONROE

Effective Oct. 1, 1983

Chairman MILLER. There is a recurrent theme this morning that is very disturbing to me. That is this question of prenatal and maternal health care. Three of you pointed out that Federal policy does not provide coverage for the first pregnancy. Yet, when we were talking with doctors at the Mailman Clinic, there seemed to be somewhat of a consensus that it was during the first pregnancy that information about the kind of care the mother should provide for herself during pregnancy was most lacking.

What have each of your States done with respect to the first pregnancy? What are you doing to provide the necessary coverage?

Ms. WEAVER. Mississippi, it is my understanding, does cover first pregnancy. However, in Mississippi, that first pregnancy is covered if you are single. In Mississippi, if you are married and poor, there is no coverage. I understand you are currently considering proposals that would help us to provide care to poor pregnant women who have no income to purchase health insurance, help them get——

Chairman MILLER. What is Arkansas's policy with respect to married women?

Mr. CRARY. We don't cover first-time pregnancies regardless of marital status. The person becomes eligible only after the birth of the child and AFDC and medicaid starts there. Medicaid can be retroactive and pickup delivery costs but it does not cover prenatal care. So we do not do that at all for single women, either.

Chairman MILLER. So other than some who are eligibile for the WIC program who might see a doctor periodically in combination with the nutrition component, there is no other program in the State?

Mr. CRARY. For the most part that is right, not in Arkansas. There are a very small number of women who receive some services under the MCH block grant. For WIC, a lot of the people who were in the WIC program say that is one of the biggest advantages of the WIC program is that it does attract the women into the clinic. They do see them. I might mention also that we have 33 counties in Arkansas that do not have health department prenatal clinics, period. So there is a crisis situation, and we pay for it I am sure through the outcomes of those pregnancies.

Chairman MILLER. I believe you are right. Again I go back to yesterday. While we saw a rather wonderful and dramatic level of medicine being delivered to these premature children, we were told that the cost was running from $1,000 to $6,000 to $7,000 and more per day. That is one obvious immediate cost we pay for not providing adequate prenatal care. But there was also substantial testimony yesterday in terms of the long-term health prospects for low birth weight babies. There are children that they had been following who are now 6 or 7 years old and who are coming back with additional difficulties. But Florida does have this program.

Mr. PINGREE. Only under AFDC. And there are other programs that might apply. There is a continuing argument relative to how much help you can provide. A lot of it is an information problem. Whether you should be providing information to children in the schools and so forth. Various State legislation has been introduced, but we find ourselves in a losing battle with certain interests at various points. It is very difficult for us to get the information out there.

Teenage pregancies have been identified for at least the past 7 years as one of the areas of priority concern within the Department of Health and Rehabilitative Services. It is not one which seems to have a lot of support when it comes to funding from the legislature or with respect to providing information to that particular target population.

Chairman MILLER. Mrs. Boggs.

Mrs. BOGGS. Thank you, Mr. Chairman. I thank all of you very much.

Mrs. LeGard, I am sorry we did not have time for you to tell us some of your recommendations that you have so specifically pointed out in your written testimony. They will be of tremendous value to this committee and to all of the people in the Congress who have jurisdiction over the various areas that you have touched. We can only get this kind of an input from the mother of 12 children who has a lively interest in their welfare and the welfare of all of their peers.

I was very interested in the health care aspects of all of your testimony, particularly in the field of teenage pregnancy. We have talked a great deal about prevention. Of course, it is the least costly in the long run, and the finest method of achieving our goals in both the long and short run. But I wonder in the prevention-of-teenage-pregnancy situations, if we should bring into coordination, as you have here in Florida, all of the groups that are out there working on drug abuse and alcohol abuse and so on. This is one area that the teens can relate to, because they already have programs that are directed toward them in these regards. Do you bring in all of the other programs that can be helpful to the people in knowing how they must react in a pregnant state, they must stay off of drugs, they must stay off of alcohol, they must, of course, take care of their nutritional problems the best way that they can?

Mr. PINGREE. We have excellent cooperation with the school system generally in the State and at the local level, but I would still have to say that the coordination is not what it should be, that in fact the first line of defense, the first place to provide information is within the schools. For our agencies to get involved is generally an after-the-fact type of thing. School systems have all that in one place and are better able to get information to them. Even though they may be coordinated, our programs are still selective: one on substance abuse, one on something else. I think the key is to utilize the school systems better than we have in the past.

Ms. WEAVER. We have in Mississippi done that on a statewide basis. However, there are a couple projects that do come to mind that have utilized within the school systems what you are talking about, comprehensive service to particularly teenaged mothers within the school setting through some funded clinics.

Mrs. BOGGS. Mrs. Weaver, I am so admiring of what Mississippi is doing with its educational system.

Ms. WEAVER. I might say, that is an important concept for the total community to feel good about in those particular cases where the clinics are operating within the school setting. It has been well-received.

Mrs. **Boggs**. I think the recent success of the programs on drunk driving among teenagers has come when they have recognized that the greatest killer of teenagers is someone who is driving while drunk, including themselves. You have been able to reach out, and the country has been able to reach out through a program that brings in the young people to combat this terrible difficulty that their teenage group finds itself in. The other great difficulty they are finding themselves in is in the area of teenage pregnancy. I would just hope that we will bring peer groups in to combat this difficulty as we have been able to dramatically with alcohol abuse.

Ms. **Weaver**. What you are saying is, we were able to do that by offering driver education in the schools. But we have not yet convinced communities of the importance in terms of both life and money, how important bringing some of these areas we are talking about, teenage pregnancies, effects of drugs, directly into the school system.

Chairman **Miller**. Mr. Bliley.

Mr. **Bliley**. Thank you, Mr. Chairman.

Currently before the Commerce Committee in the House on which I sit there is legislation that would extend prenatal care under the medicaid program. I would be interested to know your opinion as to whether or not if this legislation were to become law, and there is some consideration for it in Washington, what is the likelihood in your State of picking it up and participating in it?

Ms. **Weaver**. Mississippi did pass as I mentioned a limited medical need provision, where if that money becomes available will enable us to utilize it immediately. In our State in rural areas some people have to travel many miles before they can find a hospital that can accept them as a patient to deliver. It also would be able to provide for that unborn baby coverage which is prenatal care which is cost effective, absolutely.

Mr. **Bliley**. Mr. Crary.

Mr. **Crary**. I think Arkansas would pick it up if it were there and there were some financial assistance. The problem is critical and is widely recognized in the State as a critical problem. I think with some assistance we would opt for that program.

Mr. **Pingree**. We support the provision for it, and I would recommend to the Governor and legislature that we participate.

Mr. **Bliley**. Perhaps through the Governors' conference the Governor can get us some additional help through the form of a resolution.

Mr. **Pingree**. He serves on that particular committee.

Mr. **Bliley**. Mrs. LeGard, I am just curious as to why so many children in Baton Rouge do not report to school until after Labor Day. Is there a particular reason from that community, or is it tradition or what?

Mrs. **LeGard**. It is a tradition.

Mr. **Bliley**. I am one who questions why we begin school, particularly coming from the South, before Labor Day anyway with some of our schools not being air-conditioned. Do you think it is a mistake really to try to begin school before Labor Day in our region?

Mrs. **Legard**. Yes, and I proposed that and could not get enough votes to get it passed. So maybe now that the board has stated this, I am of the opinion that the attorney general is going to uphold it, but it was just timing, maybe now we will be able to get it done that way.

Mr. **Bliley**. Did they ever tell you the reason why they began to start before Labor Day?

Mrs. **LeGard**. Before I got on the board we, you know, addressed the board on several occasions. And they felt that they did not want to have school last longer, you know, this meant we would have to go a little longer than the end of the time, May 30. So teachers and some administrators just felt it might be wise. And the few days they missed before Labor Day were not important, so they say, anyway. But it is important.

Mr. **Bliley**. Yet they say if you miss 10, you are out, you have to repeat the grade if you miss 10 days.

Mrs. **LeGard**. Right.

Mr. **Bliley**. Catch-22.

Mrs. **LeGard**. I think it is going to force the board to pass the resolution starting school after Labor Day because many students are either working or——

Mr. **Bliley**. Have to work.

Mrs. **LeGard**. That is right, and that is why they do not report. Very few would be because of vacation. Most of them is because they are working and need that extra money.

Mr. **Bliley**. Thank you.

Thank you, Mr. Chairman.

Mrs. **LeGard**. May I just—I was asked by Mrs. Cole, who is the food service director, to ask you if you would support House bill 19—S. 1913 and H.R. 4056, which relates to nutrition and is really important for the children.

Chairman **Miller**. Thank you.

What is the situation with respect to the waiting list for pregnant women who are currently qualified and on waiting lists in areas of your State that do not have the WIC program?

Ms. **Weaver**. I am sorry, I do not have that information from Mississippi, unfortunately.

Mr. **Pingree**. We have WIC operational in all 67 Florida counties, and there is no waiting list.

Chairman **Miller**. You have no waiting list currently in Florida.

Mrs. LeGard, as you know I am a very strong advocate of parental involvement in education. I dare say that the parents of those Chapter 1 students were probably responsible for pointing out to the Federal Government mismanagement and misuse of those funds far beyond anything our own auditors did. What we have found is that parents have become rather sophisticated in the law, in understanding that the Congress has made a very conscious decision about what those funds were to be used for. And I must say, in my own area that I represent, Chapter 1 parents probably provided more headaches for that local school board than anyone. But the parents also turned out correct each and every time, including before the Supreme Court.

This was not supposed to be a free pot of money that was to be used at the discretion of the board. It was specifically targeted funds that, over a period of time, returned some rather dramatic results for those children who resided in districts where they are properly used. Unfortunately, parental involvement is no longer mandated as it once was. I think one of the best developments we are now seeing in education is inviting all parents back to school, after flushing them out with new math some 20 years ago. We have now determined that 2 and 2 is still 4, and that they are welcome to come back. So perhaps we will extend parental involvement to rich and poor parents alike in the future.

Also on that point I think it is very interesting that while education jumped to the front pages of the national periodicals and newspapers, and politicians were beating their chests and arguing over whether we were going to put up $11 billion or $14 billion for new education initiatives at the national level, that there was the State of Mississippi deciding to take the initiative to improve their own system. It seems to have begun with the Governor actually going somewhat over the head of the legislature at one point, and then the legislature coming back and deciding to substantially upgrade that system. I guess this is your first year and first semester. It will be very interesting for those of us who sit on the Education Committee to watch your effort. I am not convinced that there are enough Federal dollars to repair this system.

Ms. **Weaver**. I did point out we put some money in place to implement it. We think that is the key.

Chairman **Miller**. Yes.

Mr. Lehman.

Mr. **Lehman**. Thank you, Mr. Chairman. I just wanted to make one comment. If poverty was a form of contraception, then we would not have my subcommittee on preventive strategies, but unfortunately or fortunately that is not the case. We have such a weird system of medical application. So I think we should educate our poor mothers to have their second child first and their first child second. [Laughter.]

We have placed poor mothers in a Catch-22 position where it is impossible for them to get the funds they need when they need it the worst. So I will support the Waxman bill that would provide medical services for first-time pregnancies, for not only the human factor but for the fact that this will save megabucks in the long run for every dollar we spend in the first-time pregnancies for poor mothers. I thank you for being here.

Chairman **Miller**. Thank you very much.

Next the committee will hear from a panel made up of Mr. Jack Levine, executive director of the Florida Center for Children and Youth; Ms. Janet Reno, who will be accompanied by Albertha Bell, from the State attorney's office in Miami; Gann Watson, who is Southeastern Public Education Programs; Roger Biamby, executive director of the Haitian American Community Association, Dade County; Michael Cupoli, director of the Section on Child Development, University of South Florida; Janet McAliley, member, Dade County Board of Education; and Jane Snecinski, director of Day Care Center, Baptist Memorial Hospital of Miami.

We will take you in that order if that is all right.

STATEMENT OF JACK LEVINE, EXECUTIVE DIRECTOR, FLORIDA CENTER FOR CHILDREN AND YOUTH, TALLAHASSEE, FLA.

Mr. LEVINE. Mr. Chairman, members of the committee, I am Jack Levine, executive director of the Florida Center for Children and Youth, a private nonprofit organization based in Tallahassee. As a note of personal introduction I want to tell you that I learned the concept of kosher on my grandma's knee. My grandmother taught me that kosher goes beyond the kitchen and what you eat and how you keep your household. It goes into the community as well, how you interact with people, and more broadly how a State handles families and children can be another definition of kosher. So I see it as my job to help make Florida a more kosher State for families to live and for children to develop.

I am going to focus my remarks on four areas: juvenile justice, status offender services, school discipline, and poverty.

In the realm of juvenile justice my perception is that we are riding on a horse that is going off in many directions. We are riding toward the future but we are also pulling back to the past. We are seeking to retain rehabilitative goals but we are weighed down by the need to punish. First comes the bad news.

Florida has the highest pretrial detention rate in the Nation. During the last fiscal year we have detained over 25,000 Florida juveniles, which is one-third of all delinquency referrals.

Funding for secure detention in the last fiscal year, $14.4 million, represents 25 percent of the State's total budget for delinquency services. Due to the detainees' preadjudicatory status, the detention program is not intended to provide treatment, just custodial care, at the cost of $40 a day, $1,200 a month.

We are also suffering an accelerated adult court transfer rate.

During fiscal year 1981–82 770 juveniles were incarcerated in Florida'a adult correctional system, 40 percent of whom were age 16 or younger. It is my perception that taking a 16-year-old burglar and placing him in an adult prison for 2 years, we are paying not only a $20,000 installment on a long-term debt, but also we are bringing added violence to our communities.

In tandem with accelerated adult court transfers, commitments to juvenile programs are at an all-time high. Although the State boasts a range of nonresidential and residential community-based delinquency programs, each of these continually operates at capacity. As a result, the State's 3 training schools are grossly overutilized, housing a total of some 1,000 youths a day. Two of the training schools house over 400 males each, in remote institutional settings.

Nearly one-half of all youths committed to State training schools are serving first commitments; they never received treatment in community programs. Less than 20 percent of the youths in training schools have any crimes of violence on record. Although State policy prohibits the placement of misdemeanants in training school, waiver of this policy occurred 144 times during fiscal year 1981–82—30 percent of these waivers permitted the placement of second degree misdemeanants in training school.

The cost of a training-school commitment is approximately $12,000 per client per year. Little of this expenditure goes for mental health services—psychologists' caseloads are at 1-to-200 ratio—and basic supervision is provided by cottage parents who earn less than $9,000 annually. My perception is putting 400 bad boys in an enclosed institution with scant treatment services produces 400 worse boys. Institutions for delinquents have never, and will never, work.

Now the good news. Despite our overexpenditure of resources for both secure detention and training schools, Florida has managed to develop an excellent continuum of services for delinquent youth which may well serve as a model for other States. Unfortunately, as secure detention and training schools consume nearly one-half of the delinquency services budget allocation, the range of more effective programing is severely restricted. A description of several innovative program models follows:

In 1978 the juvenile alternatives services project [JASP] was piloted in three districts of the State. JASP is a court diversion program for nonserious juvenile offenders which provides appropriate services and sanctions such as arbitration, restitution, family counseling, and community work services. After initial evaluations reported low recidivism—less than 20 percent—JASP was expanded over the years to all districts. In fiscal year 1982–83, 16,000 clients were served, more than 300,000 hours of community work service were performed, and restitution payments reached nearly one-quarter million dollars [$228,834]. JASP services are provided at a per-client cost of approximately $170.

The nonsecure detention program provides intensive supervision to youths in prehearing status at one-third the cost of secure detention placement. All evaluations show that this alternative to secure confinement is successful in that the youths appear at their hearings and are not accused of additional offenses in the interim.

We have excellent nonresidential delinquency programs that serve some 24,000 youths with services ranging from community control supervision to marine science skills treatment programs. The latter, contracted with a private provider, evidences the lowest recidivism rate of all delinquency services available in Florida.

Community-based residential commitment programs served 2,284 youths in fiscal year 1983–84. A range of such programs exist from a 28-day wilderness survival model to group homes to more traditional halfway houses. Several of these programs are contracted with private providers, while the majority are State-operated facilities. Recidivism rates from community-based programs are more favorable than those of training schools.

We have the potential to properly support the continuum of effective, cost-efficient programs if resources were shifted away from costly detention lockup and institutional training schools.

Moving to status offender services, approximately 25,000 children were referred last year to the department of HRS for a range of status offenses. The great majority of these youths received no services. Those that come to court frequently are put under court order, and that order basically states do not repeat your truancy behavior; do not run away from home; obey your parents. We perceive these court orders to be paper authority and nothing more. When a child is brought back in front of the judge, frequently a finding of contempt of court is the response of the judge. With increasing frequency we are finding that contempt also means a stay in secure detention.

The legislature called upon the detention center superintendents to report on three specific days within the last 2 years how many clients they were housing who were status offenders held on contempt of court. The results were shocking. Over 10 percent of our detention population were there on status offenses. These children served twice the time accused delinquents were serving.

Secure detention certainly prevents status offense behavior during the term of incarceration. There are no parents to disobey. The child cannot run through the walls or steel doors. Attendance at the on-facility school is mandatory. But our perception is such confinement operates to inflict more harm than good. It is a forced choice that cripples any chance to solve the child's myriad problems which are, of course, social, familial, and, of course, based in the school.

In examining the problem of delinquent and dependent children the role of the school cannot be ignored.

Although schools are responsible for the enforcement of attendance laws, few schools have effective programs to do this. The truant or misbehaving child is viewed as a discipline problem who requires punishment. Some facts will underline this. In the 1981–82 school year over 180,000 Florida public school students received corporal punishment on one or more occasions. We do not know how many instances that translates into as incidents are reported to the State once per child per year. That could mean once a week, once a month, we just don't know the depth of the problem. I believe violence begets violence and that humiliation begets disrespect.

In 1980–81, over 83,000 students were suspended from Florida public schools. Again this is a single child count. The child can be suspended up to 10 days. A child can be suspended once a month up to 10 days and will still be counted once in the statistics. There is a Catch-22 with suspensions. There is something called the academic penalty which means that if you do not attend class a certain specified number of days you will receive a failing grade. Suspensions are unexcused absences. Therefore, being suspended from school frequently means failure from school. This translates into a horrible dropout rate in Florida; for every two graduates, one child will drop out.

We do have an excellent alternative education statute on the books. But the programmatic implementation is sporadic. That is evidenced by our discipline rates and dropout rate. The 1983 legislature made graduation requirements more stringent. My fear is that raising the academic standards will force even higher dropout rates, increasing the population of undereducated, frustrated, and very desperate young people.

I will briefly touch on some poverty issues, because there is some overlap with previous testimony. Seventy percent of Florida's poor receive no cash assistance. For those who do, the basic cash rate for a mother with two children is $209. Add to that $190 per month food stamp rate. We are talking about a per child per day payment for food, clothing, transportation and shelter of $4. I do not know how a person can survive on that subsistence level without being guilty of either neglect or fraud. Our AFDC payments in Florida have increased just 12 percent over the past decade. Our prison budget in Florida, on the other hand, has increased over 1,000 percent in the past decade. It is my perception that in many aspects of family services we are pennywise and $10,000 foolish.

Thank you.

Chairman MILLER. Thank you.

[Prepared statement of Jack Levine follows:]

PREPARED STATEMENT AND SUPPORTIVE DOCUMENTATION OF JACK LEVINE, EXECUTIVE DIRECTOR, THE FLORIDA CENTER FOR CHILDREN AND YOUTH

JUVENILE JUSTICE

As is the case nationwide, Florida is experiencing a philosophical and fiscal tug-of-war over the issue of juvenile justice. The continuous struggle between rehabilitation and punishment has resulted in major statutory revisions in Florida in four of the past five years. In budgetary terms, the state is trying to pay for both treatment and punishment, and this dual emphasis has diluted the potential for rehabilitative success.

In 1982, approximately 75,000 youths aged 17 and under were arrested in Florida—a decrease of 25 percent over the past five years. Less than 7 percent of all arrests of young people are for crimes of violence. The public perception, however, fueled by sensational reports of isolated serious crimes perpetrated by juveniles, is that youth crime is on the rise, and young people are responsible for the majority of serious offenses. The justification for such perceptions is probably due to an actual rise in crime rates of the 18 to 25 year-old group; but the resultant outcry to "get tough on kids" has been scattershot, and proves detrimental to the younger class of juveniles.

Examination of Florida's juvenile justice system reveals several disturbing trends:

Florida has the highest pre-trial detention rate in the nation. Fiscal year 1982-83 (July 1, 1982–June 30, 1983) saw 25,809 youths admitted to secure detention—over one-third of all delinquency referrals during that same period. The total average daily population in Florida's 20 regional detention centers was 1,016 youths, who were detained an average of 12.7 days each.

Funding for secure detention ($14.4 million in fiscal year 1982-83) represents 25 percent of the state's total budget for delinquency services. Due to the detainees preadjudicatory status, the detention program is not intended to provide treatment, just custodial care at the cost of $40.00 per child per day.

1981 statutory changes permit the transfer of 16 and 17 year-olds for adult court prosecution at the discretion of the state attorney. The sole criterion for this transfer is a felony charge, and no prior record needs to be in evidence. During 1982, some 3,000 juveniles were waived to the adult court, and were subject to pre-trial jailing and possible incarceration within the prison system. During fiscal year 1981-82, 771 juveniles were incarcerated in Florida's adult correctional system, 40 percent of whom were aged 16 or younger.

In tandem with accelerated adult court transfers, commitments to juvenile programs are at an all-time high. Although the state boasts a range of non-residential and residential community-based delinquency programs, each of these continually operates at capacity. As a result, the state's three training schools are grossly over utilized, housing a total of some 1,000 youths per day. Two of the training schools house over 400 males each, in remote institutional settings.

Nearly half of all youths committed to state training schools are serving first commitments; they never received treatment in community programs. Less than 20 percent of the youths in training schools have any crimes of violence on record. Although state policy prohibits the placement of misdemeanants in training school, waiver of this policy occurred 144 times during fiscal year 1981-82 (30 percent of these waivers permitted the placement of second degree misdemeanants in training school).

The cost of a training school commitment is approximately $12,000 per client per year. Little of this expenditure goes for mental health services (psychologists' caseloads are at 1:200 ratio) and basic supervision is provided by cottage parents who earn less than $9,000 annually.

Despite the overexpenditure of resources for both secure detention and training schools, Florida has managed to develop an excellent continuum of services for delinquent youth which may well serve as a model for other states. Unfortunately, as secure detention and training schools consume nearly half of the delinquency services budget allocation, the range of more effective programming is severely restricted. A description of several innovative program models follows:

In 1978, the Juvenile Alternative Sources Project (JASP) was piloted in three districts of the state. JASP is a court diversion program for non-serious juvenile offenders which provides appropriate services and sanctions such as arbitration, restitution, family counselling and community work services. After initial evaluations reported low recidivism (less than 20 percent), JASP was expanded over the years to all districts. In fiscal year 1982–83, 16,000 clients were served, more than 300,000 hours of community work service were performed, and restitution payments reached nearly one-quarter million dollars ($228,834). JASP services are provided at a per client cost of approximately $170.

The Non-Secure Detention Program provides intensive supervision to youths in pre-hearing status at one-third the cost of secure detention placement. During fiscal year 1982–83, 5,873 youths were served in non-secure detention status, with an average daily population of 364. All evaluations show that this alternative to secure confinement is successful in that the youths appear at their hearings and are not accused of additional offenses in the interim.

Non-residential delinquency programs served some 24,000 youths during fiscal year 1982–83, with services ranging from community control supervision to marine science skills treatment programs. The latter, contracted with a private provider, evidences the lowest recidivism rate of all delinquency services available in Florida. The per client cost for non-residential services is approximately $11.00 per day.

Community-based residential commitment programs served 2,284 youths in fiscal year 1983–84. A range of such programs exist from a 28-day wilderness survival model to group homes to more traditional halfway houses. Several of these programs are contracted with private providers, while the majority are state operated facilities. Recidivism rates from community-based programs are more favorable than those of training schools.

Florida has the potential to properly support the continuum of effective, cost-efficient programs if resources were shifted from costly detention lock-up and institutional training schools. High expenditure for these two least successful programs hampers the ability of Florida to achieve its goal of rehabilitative treatment for young people who get into trouble with the law.

STATUS OFFENDERS

During 1982, approximately 25,000 children were referred to the state of Florida as either runaways, truants, or generally being beyond the control of their parents (ungovernable). Of this total, some 40 percent are local (in-county) runaways, 30 percent of the referrals are for ungovernability, 20 percent for truancy, and 10 percent are out-of-state runaways.

The large majority (88 percent) of status offense referrals are handled informally, without the intervention of the court. In nearly all of these cases, no further action or referral is made by the state due to the dearth of appropriate voluntary community resources (e.g., mental health, crisis counselling). The children who exhibit status offense behavior may come before court and be adjudicated dependent. This adjudication usually is followed by the issuance of an order which prohibits the child from continuing the behavior. In addition nearly half (45 percent) of judicially handled status cases are placed under protective supervision and 12 percent are placed in foster care.

Due to the complexity of familial, social, school and personal problems which give rise to status offense behavior, the order of the court to cease such activity is frequently a meaningless gesture of authority in the eyes of the child. The court order does nothing to sort out these problems, and as a result, the behaviors usually reoccur. With increasing frequency, repeated appearances before the court for running away, truancy or general disobedience evokes a finding of contempt of court, and a sentence to secure detention.

At the request of the legislature several single days surveys of detention populations were conducted in 1982 and 1983 to determine the prevalence of court-ordered confinement for chronic status offense behavior. These surveys revealed that as many as 10 percent of the detainees in secure lock-ups were status offense cases. These children, many of whom were serving specified sentences, remained in detention twice as long (24.8 days) as youths who were held pending delinquency hearings. No provisions for separating the two groups of children were mandated or implemented.

Secure detention certainly prevents status offense behavior during the term of imprisonment. The child cannot run though the solid block walls or steel doors, there are no parents to disobey, and attendance at the on-facility school program is mandatory. But such confinement operates to inflict more harm by aggravating the complex problems which give rise to status offense behavior. Out of familial, school, and court frustraton, and the lack of effective treatment resources, incarceration is the expedient option. But it is a forced choice which cripples the chance to solve the real problems of the child.

EDUCATION

In examining the problems of children identified as status offenders, the role of the school cannot be ignored. While truancy accounts for a fifth of status referrals, sporadic school attendance and misbehavior are also characteristic of runaways and children who are labelled as ungovernable.

Although schools are responsible for the enforcement of compulsory attendance laws, few school districts in Florida have effective programs to respond to the complex reason for nonattendance or misbehavior. The truant or misbehaving child is viewed by school administrators as a discipline problem who requires punishment. This tendency to punish shows itself in these statistical indexes:

In 1981–82, over 180,000 public school students received corporal punishment on a single or on numerous occasions.

In 1980–81, over 83,000 students were suspended from public schools.

In 1980–81, over 40,000 young people dropped out of public schools and another 112,000 were not promoted to the next highest grade.

In July, 1979 the federal Office of Civil Rights released a major study entitled "Elementary and Secondary Schools Civil Rights Survey". This report included a ranking of the 100 worst school districts in the nation for overrepresentation of black students who were corporally punished, suspended or expelled. Ten Florida school districts were in the ranking:

District:	*No. in ranking of 100*
Pinellas	7
Hillsborough	20
Brevard	35
Escambia	36
Broward	39
Dade	52
Polk	67
Palm Beach	68
Lee	71
Seminole	96

These districts are 10 of the 12 largest Florida school districts, encompassing nearly 60 percent of the state's public school population.

In the 1980–81 school year, black students comprised 23 percent of the Florida public school population but represented 33 percent of the non-promoted students, 37 percent of the corporally punished students, 38 percent of the suspended students and 43 percent of the students who were expelled.

A majority of Florida's school districts operate alternative education programs. These programs are designed to provide special help for students who are disruptive or unsuccessful. While the intent of the Alternative Education Act is to offer educational programs which would be positive rather than punitive, and emphasize each student's abilities, close examination of the programs within most school districts reveals a perversion of that intent. One investigation, initiated by the Governor's office, concluded that the alternative education programs have been generally ineffective. The study found marked philosophical rifts between state and district administrators, little evidence of cooperative planning within school districts, and few innovative ideas in the offering of nontraditional learning experiences for disruptive, disinterested and unsuccessful students. The prime recommendations of the study focused directly upon local initiative in planning and implementing pro-active alternative programs.

While changes in school curriculum to make a child's education more challenging is a primary strategy toward resolving truancy and conduct problems, school administrators cannot act alone in this effort. Increased ties with community agencies are essential for proper handling of family-based problems. At present, schools operate in a vacuum. Social services are used so infrequently that crisis points must often be reached—and then a court referral is the usual response. The coercion of the court, in most matters of family and school problems, is an ineffective measure. The challenge to communities is to orchestrate professional and volunteer resources that will work to respond to and remediate the complex problems of young people who are not building foundations for their future. Punitive responses, which have been the rule in Florida, only result in escalating drop-out rates, and a population of unskilled, frustrated, desperate young people.

The Florida Center for Children and Youth is a nonprofit advocacy organization made up of thousands of Floridians who are concerned with the problems of our state's children and their families. The Center provides information to county-based groups of child advocates, the Children's Action Network, on a range of children's issues—nutrition, mental health, child care, adoption, education, juvenile justice, and others.

Over the past seven years, the Center has built a successful partnership for progress with local child advocates. Among our shared accomplishments are the passage of important child abuse legislation, the strengthening of services to runaway teenagers, and the improvement of education in Kindergarten—3rd grade (see accomplishments list, attached).

Each affiliate of the Children's Action Network (see map, attached) is led by a team of volunteer coordinators who are trained by the Center to recruit participants, conduct community meetings, and make contacts with officials on the local and state levels.

Information on children's concerns is disseminated regularly through the FCCY Newsline and the Legislative Update, Publications of the Florida Center for Children, and Youth.

The Center's office in Tallahassee houses an Executive Director and a part-time Administrative Assistant. These individuals serve as the eyes and ears of local child advocates. Center staff monitor the legislature, the Cabinet, and the State agencies (Dept. of HRS, Education, Corrections) for issues and actions which affect children's lives in Florida. The Center serves as both a receiver of information from county affiliates, and a sender of information back to the counties. This three way communication—The Children's Action Network, the Center, and policy makers—is the key to effective child advocacy in Florida.

The Center's function is a valuable supplement to the important services provided in each community by local agencies—e.g. adoption counselling, shelters for abused children, drug rehabilitation. Because the Center works to improve laws, state policies and budget allocations, local family agencies derive direct benefit from our statewide efforts.

The strength of the Florida Center for Children and Youth depends upon the commitment of volunteers and the support of individuals, service agencies, organizations and businesses who believe that there is a value to a unified voice for our children.

THE FLORIDA CENTER FOR CHILDREN AND YOUTH

CHILD ADVOCACY ACHIEVEMENTS

I. Enhanced programs for prevention and treatment of child abuse and neglect

1977—Passage of HB 402 which strengthened provisions of Chapter 827, Florida Statutes relating to the reporting of suspected child abuse.

1978—Establishment of pilot Child Protection Team in one HRS District IV. Established provisions for the appointment of Guardians Ad Litem in abuse and neglect cases.

1979—Passage of CS/HB 1433 further strengthening the child abuse reporting statute. Expansion of Child Protection Teams for four additional HRS Districts.

1980—Guardian Ad Litem funding provided for seven judicial circuits. Intensive Crisis Counselling Program established as a support service for families.

1981—Increases in protective services staff established in three HRS Districts as pilot project. Intensive Crisis Counselling Program expanded to four additional HRS Districts. Guardian Ad Litem funding extended to three additional judicial circuits. Child Protection Teams expanded to three additional HRS Districts. Child Abuse Registry system funded for computerization of information.

1982—Passage of HB 296 (Mills Bill) providing for planning and implementation of statewide program for prevention of child abuse and neglect. $1.1 million appropriated to fund programs proposed by planning process. Continuation of Intensive Crisis Counselling Program. Expansion of Homemaker Service Program to provide parenting skills training. Expansion of Guardian Ad Litem Program. Loss of federal funds for Child Protection Teams picked up by state revenues.

II. Strengthening requirements for judicial review of foster care placements to expedite child's return to natural parent or placement in permanent adoptive home

1977—Statutory expansion of "special needs" adoption category to include sibling groups. Increased appropriations for adoption workers within state child welfare delivery system.

1978—Passage of SB 248 which provided subsidies for special needs adoptions through the adoptee's 18th birthday, rather than just for three years after placement.

1979—Legislature improves funding of Specialized Family Services and Adoption Services in order to promote better attention to permanency needs of foster care clients.

1980—Passage of SB 357 (Skinner Bill) requiring permanency plans within 30 days of foster care placement; prohibiting parental waiver of judicial review; requiring proof that other options were explored prior to foster care placement of child. Passage of CS/SB 533 requiring annual status reports by Department of HRS on children in foster care. Foster care suit, *Quaintance* v. *Pingree* enforces requirement for judicial review of foster care placement. Expanded training for foster care workers and foster parents provided through appropriations. Expanded funding of special needs adoption subsidies.

1981—Adoption subsidy funding level improved to equal foster care reimbursement rate. Improved funding of medical payments for special needs adoption placements.

1982—Passage of HB 738 providing for safeguarding interests of parties in intermediary adoptions and determining criteria for confidential handling of adoption information. Funding shifts away from foster care program into adoption services including subsidy payments for special needs placements.

III. Improved public education by reducing exclusionary practices and enhancing alternative education programming

1978—Passage of HB 282 (Florida's Alternative Education Act) which provides statutory definition and enhanced F.T.E. funding for disinterested, disruptive and unsuccessful students.

1979—Passage of HB 1327 to provide for equitable funding of education programs for children who are placed in residential care of the Department of HRS. Passage of statutory guidelines for due process rights of children who are corporally punished in school.

1980—Defeat of legislation which would have expanded use of suspension for "serious breach of conduct" without prior inclusion of parents in process. Defeat of legislation which would have removed principal's authority to prohibit the use of corporal punishment. Passage of HB 222 expanding requirements for school districts to provide education programs for pregnant students.

1981—Defeat of numerous measures in Legislature which would have broadened the authority of school officials to suspend and expel students. SB 299—requiring automatic suspension if student is charged with a property offense. HB 414—granting broad exemption from use of parental assistance prior to suspension. SB 295—expanding time of suspension beyond 10 days. SB 154—permitting suspension for truancy. HB 479—imposing financial penalties on parents if child did not exert "minimum expenditure of effort" to complete school work. HB 779—terminating family's AFDC payments if child violates compulsory school attendance law.

1982—Improved funding by 10% of per-student allocation for alternative education. Improved funding for student development services—including guidance counsellors, placement specialists and career counsellors. Creation of statewide Task Force on Truancy and Discipline which has as its purpose an examination of policies and practices which impede educational participation by students. Task Force has requirement to report to Legislature regarding findings and recommendations.

IV. Reduce institutional placement of emotionally disturbed children and expand access to appropriate community-based services for these children

1979—Legislature appropriated $4.5 million for a range of community-based mental health services for children.

1980—Passage of HB 1643 requiring comprehensive county plans to include provisions for the location of residential group homes. Improved funding for community-based purchase of services for emotionally disturbed children.

1981—New appropriations for mental health day treatment programs. This provided funds to supplement local school district's programs with family services and after-school treatment. Improved appropriations for community residential mental health programs—therapeutic foster care and therapeutic group homes.

1982—Passage of CS/HB 665—revising major provisions of Florida Mental Health Act. Changes included separation of children from adults on wards of state hospitals; requirement to document attempts at placement of children in least restrictive setting; elimination of hearing waiver provisions in cases of involuntary placement of minors in residential settings; requirement for Department of HRS to submit deinstitutionalization plan to the Legislature in order to accomplish goal of community services for children in need of mental health care. Increased appropriations for nonresidential service programs for emotionally disturbed children—out-patient care for foster children, prevention projects, specialized children's programs in community mental health settings, and HRS day treatment programs.

In addition to the four categories of child advocacy achievement delineated above, Florida has improved services to children in several other areas, in part as a result of strong child advocacy activities:

PREP program.—The 1979 Legislature passed the Primary Education Act (PREP) to improve the quality of educational programs in kindergarten through third grade. The four components of PREP are: (1) health and education screening to evaluate learning potential and to identify any handicaps which might impede the child's ability to learn; (2) individual instructional strategies suited to children's specific needs; (3) reduction in class size to enhance teacher/student interaction; and (4) staff development and training to enable school personnel to improve their professional skills. PREP funding has increased in each budget year since the initial 1979-80 implementation of the program.

Perinatal intensive care program.—This program represents one of the premiere efforts in Florida to establish true primary prevention of health and emotional disorders in children. During their eight years of operation, Florida's perinatal intensive care centers have served more than 15,000 women who were high risk obstetric patients and over 25,000 newborns who required intensive health services for survival and proper early development. The program also conducts developmental evaluations of children up to age four—more than 4,000 evaluations were accomplished in FY 1981-82. Increased funding for more perinatal centers—numbering six in 1976 and increasing to 10 in 1982—has been a major achievement of child advocates in Florida.

Aid to families with dependent children.—The AFDC program provides payments to families which are unable to manage due to extreme poverty. Three quarters of the recipients of AFDC payments are children, the remainder being sole caretakers and disabled persons. Florida AFDC payments have traditionally been among the lowest in the nation. In February, 1983, as a result of a payment level increase, AFDC payments for a family of four (one parent and three children) total $263 per month. Expenses to be covered by this amount are shelter, utilities, transportation, clothing, and household supplies. Florida's AFDC rules do not permit an intact family to receive payments. Therefore, if two parents are unemployed, the father must abandon the family in order for the children to receive AFDC.

Despite this dismal picture, Florida's AFDC program has realized slow, but steady improvements in both payment levels and increased standards of need. Although the payment level remains near the bottom nationally, standards of need adjustments allow more needy children to participate in the program.

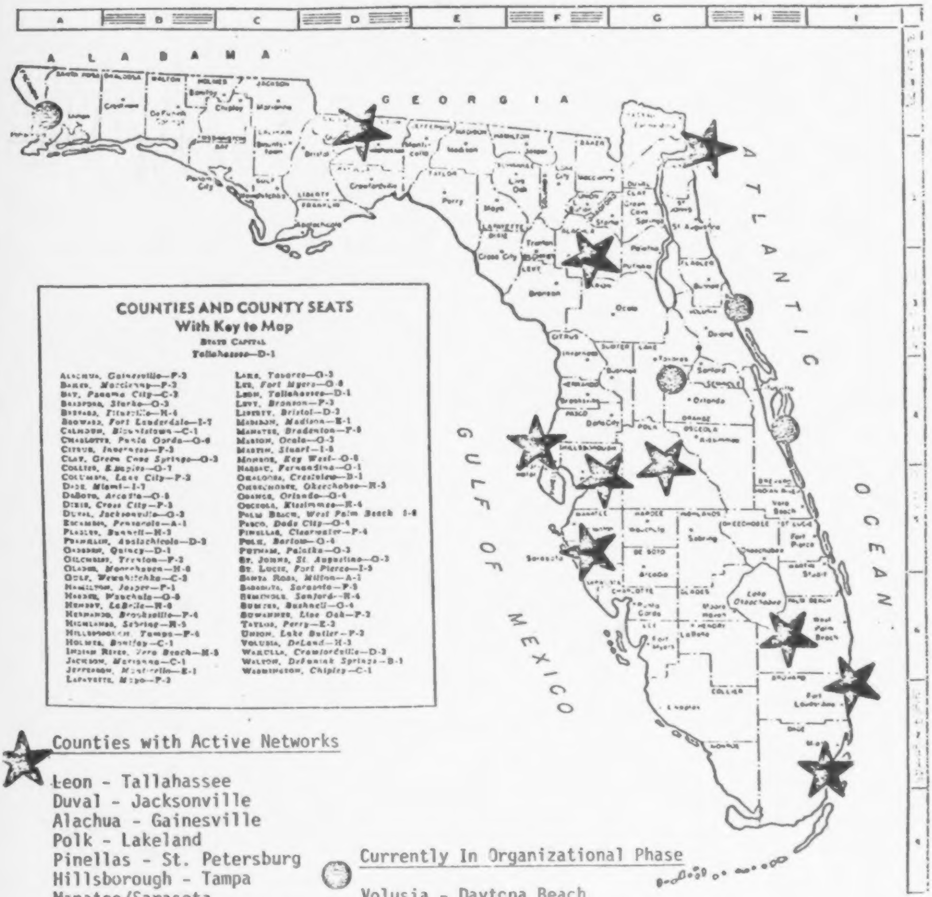
Day care—title XX.—This program provides quality day care to children of low income families. The purpose of Title XX Day Care is to permit parents to work, obtain job training, or pursue further education so that their families can become more self-sufficient. The state and local communities pay approximately 25% of the Title XX Day Care costs, and 75% is paid by federal dollars. For every dollar spent on this program, more than two dollars of tax revenue is generated by the working parent.

Improvements to Title XX Day Care services in Florida are two-fold. There has been a steady increase in the numbers of children served—FY 1981-82, 18,380—and concommitant increases in the maximum reimbursement rates for providers of infant and pre-school care. Despite steady improvements, economic conditions have increased the need for care, and waiting lists in Florida have some 15,000 children in need of care.

Juvenile alternative services project (JASP).—The JASP began in 1978 in three pilot HRS Districts to establish diversionary programs to keep first-time nonserious offenders out of formal court processing. The range of services includes community arbitration, restitution to victims, local work assignments for community agencies and family counselling. JASP was a component of the resource reallocation plan to improve "upfront" delinquency services, thereby reducing recidivism into the system. Cost savings and reduced criminal involvement by juveniles are the goals of the plan. Since 1978, JASP has been evaluated to show great success on both measures. As a result, the project has been expanded to each of the 11 HRS Districts. JASP continues to serve the community through use of a core counselling staff, supplemented by volunteer arbiters, and excellent cooperation from law enforcement agencies, the state's attorneys and judges.

Runaway youth shelters.—Florida's network of runaway youth centers, which number 11 statewide, provide 24-hour, 7-day per week supervised child welfare services to children who are away from home. Research reveals that a great majority of runaway youth are in need of therapeutic, supportive treatment due to damaging experiences of physical and emotional abuse. In 1981, Florida took an important step in maintaining vital shelter services by replacing $307,000 which has been cut from Florida's allocation at the federal level. In 1982, the Legislature supplemented its 1981 appropriation with an additional one-half million dollars to augment runaway services to include more family counselling and follow-up services. The 1983 Legislature acted to mandate the creation of a statewide task force to develop a comprehensive plan for runaway youth—including evaluation criteria for shelter programs.

Children's Action Network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ALABAMA
GEORGIA
ATLANTIC OCEAN
GULF OF MEXICO
COUNTIES AND COUNTY SEATS
With Key to Map
State Capital
Tallahassee—D-1
Alachua, Gainesville—F-3
Baker, Macclenny—F-2
Bay, Panama City—C-3
Bradford, Starke—G-3
Brevard, Titusville—H-4
Broward, Fort Lauderdale—I-7
Calhoun, Blountstown—C-1
Charlotte, Punta Gorda—G-6
Citrus, Inverness—F-3
Clay, Green Cove Springs—G-3
Collier, E Naples—G-7
Columbia, Lake City—F-2
Dade, Miami—I-7
DeSoto, Arcadia—G-5
Dixie, Cross City—F-3
Duval, Jacksonville—G-2
Escambia, Pensacola—A-1
Flagler, Bunnell—H-3
Franklin, Apalachicola—D-3
Gadsden, Quincy—D-1
Gilchrist, Trenton—F-2
Glades, Moore Haven—H-6
Gulf, Wewahitchka—C-2
Hamilton, Jasper—F-1
Hardee, Wauchula—G-5
Hendry, LaBelle—H-6
Hernando, Brooksville—F-4
Highlands, Sebring—H-5
Hillsborough, Tampa—F-4
Holmes, Bonifay—C-1
Indian River, Vero Beach—H-5
Jackson, Marianna—C-1
Jefferson, Monticello—E-1
Lafayette, Mayo—F-2
Lake, Tavares—G-3
Lee, Fort Myers—G-6
Leon, Tallahassee—D-1
Levy, Bronson—F-3
Liberty, Bristol—D-2
Madison, Madison—E-1
Manatee, Bradenton—F-5
Marion, Ocala—G-3
Martin, Stuart—I-5
Monroe, Key West—G-8
Nassau, Fernandina—G-1
Okaloosa, Crestview—B-1
Okeechobee, Okeechobee—H-5
Orange, Orlando—G-4
Osceola, Kissimmee—H-4
Palm Beach, West Palm Beach I-6
Pasco, Dade City—G-4
Pinellas, Clearwater—F-4
Polk, Bartow—G-4
Putnam, Palatka—G-3
St. Johns, St. Augustine—G-3
St. Lucie, Fort Pierce—I-5
Santa Rosa, Milton—A-1
Sarasota, Sarasota—F-5
Seminole, Sanford—H-4
Sumter, Bushnell—G-4
Suwannee, Live Oak—F-2
Taylor, Perry—E-2
Union, Lake Butler—F-2
Volusia, DeLand—H-3
Wakulla, Crawfordville—D-2
Walton, DeFuniak Springs—B-1
Washington, Chipley—C-1

★ Counties with Active Networks

Leon - Tallahassee
Duval - Jacksonville
Alachua - Gainesville
Polk - Lakeland
Pinellas - St. Petersburg
Hillsborough - Tampa
Manatee/Sarasota
Palm Beach - W. Palm Beach
Broward - Ft. Lauderdale
Dade - Miami

● Currently In Organizational Phase

Volusia - Daytona Beach
Brevard - Titusville/Melbourne
Escambia - Pensacola
Orange - Orlando

STATEMENT OF TOM PETERSEN, CHIEF ASSISTANT STATE ATTORNEY, THE ELEVENTH JUDICIAL CIRCUIT OF FLORIDA, DADE COUNTY, ACCOMPANIED BY ALBERTHA BELL

Mr. PETERSEN. Let me point out the obvious. I am not Janet Reno. Unfortunately, she has been in Tallahassee today. I am her chief assistant, Tom Petersen. To my left is Albertha Bell. Ms. Bell and I are going to share our lot. In doing so I think we will amplify on Mr. Levine's remarks.

I think there have been few who would question the proposition that delinquency among our youth is directly related to poverty. Data indicate to an alarming extent that delinquency is related to single-parent families. This is especially acute in inner-city families. We found that 83 percent of black children in a study came from one-parent homes. As to the connection between poverty and the black, single-parent family, a report produced by the Center for Study of Social Policy in Washington, D.C., found that not only had the difference between black and white family income remained relatively constant between 1960 and 1981, blacks have during the same time period consistently been three times more likely to live below the poverty standard than whites, and the poverty rate for blacks is most severe for children and elderly. In 1981, 45 percent of all black children under age 18 lived in poverty, while only 15 percent of all white children. For children in black, female-headed families, which comprise almost half of all black families with children, in 1981 the poverty rate was 68 percent, and 81 percent of black children under age 6 in female-headed households in inner-city areas were poor. Yet there is darkness at the end of the tunnel. In 1960, 20 percent of all black families in the United States were female headed. By 1970 the percentage was 30 percent, and by 1980, 47 percent, with more than half of all these families living below the poverty level.

In a recently published book entitled "The Underclass" this phenomenon was described as the feminization of poverty, and noted while the number of families headed by men declined 25 percent from 1970 to 1977, the number of women who headed families below the poverty line jumped by 710,000, or 39 percent. He further pointed out that the 13th annual report of the President's National Advisory Council on Economic Opportunity published in September 1981 carried a troubling warning, and I quote:

> All other things being equal, if the proportion of the poor in female households or families were to continue to increase at the same rate it did from 1967 to 1978, the poverty population would be composed solely of women and their children before the year 2000.

What do these figures mean in terms of delinquency prevention? They clearly imply that instead of pursuing panaceas for eradication of all delinquency we should instead focus on specific problem areas which most need addressing. The salient problem area is that of the black single mother living below the poverty level and her children. The number of these families as I have stated has increased dramatically during the last decade. If the relationship does exist between delinquency and poverty and poverty and inner-city single-parent family, we should not be surprised if 10 years from now the urban delinquency rates will be significantly larger than they are today.

The data clearly suggest this prognosis is ominous, particularly in light of the fact that our response to the situation is a welfare system which perpetuates and even aggravates the problem. For example, take Ms. Bell. In 1980 Ms. Bell is an AFDC recipient with four children. By virtue of her own initiative she is no longer on welfare and is employed and going to school in the evening. In Florida in 1980 the monthly AFDC payments for a family of five was $520 per month, $6,000 per year. This represents 66 percent, two-thirds of the Federal poverty level. Ms. Bell enrolled in a CETA-subsidized secretarial training program for about 30 hours a week and during a 4-month period received a monthly stipend of $340. During that 4-month period her combined AFDC, food stamp, and CETA subsidy annual income would have amounted to $8,000 if she continued to receive that for a full year. That represents 108 percent of the Federal poverty level. The simple reality is that welfare even when combined with an undeclared employment or training stipend leaves most recipients barely at the poverty level. She failed to report this and was charged with a felony for not having done so. Last year that would have meant arrest, booking, and criminal record. Fortunately this year it means Ms. Bell will be working to institute a free day-care center designed to benefit other parents who wish to seek employment or training. She is participating in a new program jointly administered by the State attorney's office and Dade Community Action Agency which is attempting to provide constructive training and community service for recipients for failing to declare employment or who are financially unable to make restitution. This program provides specified hours of community service or vocational or educational training. It must be completed as prerequisite to the dropping of criminal charges.

In addition we have instituted an early intervention effort, a program which is placed in an elementary school in Liberty City which is designed to provide aftercare, sort of a Head Start program for children exhibiting difficulties in school. The school has 92 percent black enrollment. In that school, 27 of 877 students come from families whose income is high enough to disqualify them for the free lunch program. This program began yesterday, simultaneously will provide tutors, cultural activities for the children identified, as well as training and educational opportunities for their parents, about two-thirds of whom will be AFDC mothers.

Now I would like to introduce Ms. Albertha Bell.

[Prepared statement of Thomas K. Petersen follows:]

PREPARED STATEMENT OF THOMAS K. PETERSEN, CHIEF ASSISTANT STATE ATTORNEY, THE ELEVENTH JUDICIAL CIRCUIT OF FLORIDA IN AND FOR DADE COUNTY

Mr. Chairman and members of the Select Committee, there are but a few who would question the proposition that delinquency among our youth is directly related to poverty. And the data indicate, to an alarming extent, that poverty is directly related to single parent family status. This problem is distressingly acute in the inner city Black community.

A study conducted here in Dade County by Judge Seymour Gelber of four hundred and ninety five adjudicated delinquents found that 83 percent of Black children in the study came from one parent homes.

As to the connection between poverty and the Black single parent family, a report produced by the Center for the Study of Social Policy in Washington found that not only had the difference between Black and White family income remained relatively constant between 1960 and 1981, but that Blacks have during the same time period consistently have been three times more likely to live below the poverty standard than Whites; and that the poverty rate, for Blacks, is most severe for children and the elderly. In 1981, 45 percent of all Black children under age eighteen lived in poverty while only 15 percent of all White children were below the poverty limit. For children in Black female headed families—families which comprised almost half of all Black families with children in 1981—the poverty rate was 68 percent. And 81 percent of Black children under age six in female headed households in inner city areas were poor.

Yet there is darkness at the end of the tunnel. In 1960 20 percent of all Black families in the United States were female headed families with children under eighteen. By 1970, the percentage had risen to 30 percent and by 1980 to 47 percent, and more than half of all these families live below the poverty level.

In a recently published book entitled "The Underclass", Ken Auletta described this phenomenon as "The Feminization of Poverty", and noted that while the number of poor families headed by men declined by 25 percent between 1970 and 1977, the number of women who headed families below the poverty line jumped by seven hundred and ten thousand (710,000) or 39 percent. He further pointed out that the thirteenth annual report of the President's National Advisory Council on Economic Opportunity, published in September of 1981, carries a troubling warning: "All other things being equal, if the proportion of the poor in female households or families were to continue to increase at the same rate as it did from 1967 to 1978, the poverty population would be composed solely of women and their children before the year 2000".

What do all these figures mean in terms of delinquency prevention? They clearly imply that instead of pursuing panaceas for the eradication of all delinquency, we should instead focus on specific problem areas which most need to be addressed. The salient problem area in delinquency prevention today is that of the Black single mother living at below the poverty level and her children. The number of these families has increased dramatically during the past decade, as has the number of Black infants growing up in poverty today.

If the relationship does exist between delinquency and poverty, and between poverty and the inner city single parent family, then we should not be surprised if ten years from now our urban delinquency rates are significantly larger than they are today. And the data clearly suggest that the prognosis is ominous.

Particularly in light of the fact that our response to this situation is a welfare system which perpetuates, even aggravates the problem. As an example, take Albertha Bell. In 1980, Ms. Bell was an AFDC recipient with four children. By virtue of her own initiative, she is no longer on welfare and is presently employed and going to school in the evening. In Florida in 1980 the monthly AFDC and food stamp payments to a family of five was at that time $520 per month, or $6,240 per year. This represented 66 percent of the federal poverty level. Ms. Bell enrolled in a CETA subsidized secretarial training program and during a four month period received a monthly stipend of $341. During that four month period Ms. Bell's combined AFDC-food stamp and CETA subsidy annual income would have amounted to $8,400 had she continued to receive that income over a full year. That represents 109 percent of the federal poverty level. The simple reality is that welfare, even when combined with an undeclared employment or training stipend, leaves most AFDC recipients barely at the poverty level. Ms. Bell failed to declare the CETA income (to do so would have returned her to ⅔ the poverty level) and she was charged with a felony for not having done so. Last year that would have meant an arrest, a booking and a criminal record.

Fortunately, this year it means Albertha Bell will be working to institute a free day care center designed to benefit other single parents who wish to seek employment or training but cannot afford to do so because of an inability to pay for day care.

Ms. Bell is participating in a new program, jointly administered by the State Attorney's Office and the Dade Community Action Agency, which is attempting to provide constructive training and community service for AFDC recipients who have failed to declare employment and who are financially unable to make restitution. The program provides that specified hours of either community service or vocational or educational training must be completed as a prerequisite to the dropping of criminal charges. These women are performing valuable community service and are eager to develop employable skills, as well as interested in creating self-run enterprises such as free day care centers for those unable to pay for the day care of their children.

Another program, based at the Edison Park Elementary school—a school with a 92 percent Black enrollment in which only twenty seven of eight hundred and seventy seven students come from families whose income is high enough to disqualify them from the free lunch program, now offers a free after care school program—from 2:00 until 6:00 p.m. This program provides tutoring and organized educational, recreational and cultural activities for children experiencing learning, behavioral or emotional difficulties. This program, the Dade County Early Intervention Program, is funded by a combination of Federal, State and local monies. Most of the children who will be enrolled in this program will be children of single parent families subsisting at below the poverty level and the program is designed to simultaneously provide for the educational, vocational training, and parenting activities to be provided to families interested in participating.

STATEMENT OF ALBERTHA BELL

Ms. **Bell**. Mr. Chairman, members of the committee, I am Albertha Bell. I am 32 years old. I live at 2101 Northwest Avenue in the city of Miami, Dade County. I have four kids. I am not on welfare at the present time. I did not like the system. I motivated myself to get off the system. In the welfare system there is a dehumanizing factor involved. You feel you are condemned to remain in this type of situation the rest of your life and you do not have enough of anything. Being a welfare recipient, there is not enough for food; new clothing is nonexistent. Your living conditions are worse. I live in the same building I lived in when I was getting a check. And it is bad. For example, the hallways of the building I live in are used for bathrooms, and there is urine running out into the streets. Many dumpsters are placed downstairs by the building, and in summertime it is like nothing you ever smelled before in your life.

The effect on the kids and myself is terrible. There is a very real possibility of delinquency involved in a system like this. My son fell into the system and got caught. He was picked up for dealing drugs. There is always that possibility with delinquency when children do not have enough of anything. You have young mothers. Some of these children are totally devoid of any type of affection. They need something. Their mothers are on welfare and parents as we all know, poverty-level parents tend not to have a great deal of love and affection for anyone, particularly themselves and their children. A young girl falls into the trap where a guy comes by and says hey, I love you. I want you to have my baby. They figure why not. I don't have to take care of it. Welfare will take care of my babies. They know they are not going anywhere. They have been culturally culturized to believe that they will never get out of the system, therefore what the hell?

There are young kids in the ghetto that were born there, raised there, and probably will die there in that same particular neighborhood. In the building where I live there is a lady, she has been there 21 years. She raised all of her children on welfare and she still has kids at home, and they are on welfare. Therefore you have generations of welfare mothers.

Every young man on the street corner sells dope. He has nothing else that he can do except sell dope. There is no food on the table, and with young children they have to do something. Dope is a very convenient way to do something. Hustling is a full-time job. You cannot hustle and go to school at the same time. You cannot go to school if you are hungry. Education means nothing. But there are solutions to this problem, and the solution has to be resolved sooner or later. It is like the social security system. There are a few taking care of a lot. This is happening every day. The solutions are education. If we do not educate these people to where they are employable, they can hold a job, they will be in the system for the rest of their lives. But you cannot educate a hungry person or hungry child. You have to feed them first. You cannot educate a child that is embarrassed because he does not have the proper clothes to wear. He has to have some type of feelings for himself. He has to like himself before you can educate him.

The system has to be changed. AFDC, the entire system has to be totally changed. It cannot automatically be cut off and expect you to survive. There has to be a gradual weaning of mothers from the system. Make it mandatory that they go to school. If they get pregnant and have a child, give them day care centers so they can get out to work or go to school. You cannot leave the child by himself. If you have children in school, afternoon care, if you do not get off until 5 in the afternoon somebody has to care for the child. You have to make people realize, we are not going to support you for the rest of your lives. It has to be a slow weaning off the system.

Social workers have a funky attitude. They have this star attitude. This is one of the reasons why I got off. I do not like crawling or bowing down to anybody. The system has to support what the recipients need. It has to give them something that is going to be very much more humanizing. They have to feel their own way. They have to gain respect, confidence, and have to know their responsibilities. You have to be able to stand up on your own two feet. If the system does not give you this, then you will be on the system for the rest of your life.

Thank you.

Chairman Miller. Thank you.

[Prepared statement of Albertha Bell follows:]

Prepared Statement of Albertha Bell, Overtown, Miami, Dade County

Mr. Chairman and members of the Select Committee, my name is Albertha Bell, I am thirty-three years old, I live at 2101 N.W. 3rd Avenue, in the heart of Overtown, in the city of Miami, Dade County.

I have four kids, the oldest is seventeen; I have one fifteen, thirteen and the youngest is ten. I am not on welfare at the present time. I didn't like the system therefore I motivated myself enough to get off the system. In the welfare system there is a dehumanizing feeling that is involved. You feel that you're condemned to remain in this type of situation for the rest of your life, you don't have enough of anything. And being a welfare recipient, food stamps just does not cut the mustard. There is no money for food, new clothing are totally inadequate, your living conditions are even worse. I live in a building now that I lived in when I was getting a check and the stairwells are used for a bathroom; I have urine running out of the stairwells, we have Dempsy Dumpsters downstairs and sometimes it smells like all hell. The effect on me and the kids is horrible. There is a possibility of delinquency involved in a system like this. My son in trying to help me and his sisters, (he is the only boy I have), fell into the system, he got picked up, he was arrested for dealing with drugs. The system causes delinquency. There is always a possibility of delinquency when children don't have enough of anything. You have young mothers, these young girls are in a system that is totally devoid of any type of affection. They need something, they need someone, their mothers are on welfare, and, as we all know, poverty stricken parents tend to not have a great deal of love for anybody or anything. They fall into this trap where a guy comes by and say "Hey, I love you, and I want you to have my baby." They realize that welfare would take care of the baby whether he is there or not, why not? They know that they are not going anywhere, they have been culturally socialized to believe that they would never get out of where they are, and there are young kids that were born there, raised there and would probably die there. A lady in my building, she has been there for 21 years, she raised everyone of her children there and she still has children at home, grown people, and they are on welfare. We have generations of welfare mothers.

In the boys, every young man in the neighborhood sells dope. When there is no food on the table and no clothes for them, their mothers, or the young kids in their family, they have to do something so they sell dope. Once they get a few dollars in their pocket, hey, the hell with school. Hustling is a full time job and you can't hustle and get an education at the same time; if you don't have any money to eat on school is not really that important.

But there are solutions to this problem and this situation has to be resolved soon or it will be like the social security system, it will be a few taking care of a lot, and that's exactly what is happening. The solutions are education: you have to educate young people, you have to educate parents, but you can't educate a hungry child. You cannot educate a child that is embarrassed because he isn't properly attired. The system has to be changed. AFDC's entire system has to be totally, totally changed within. There has to be a gradual weaning of mothers from the system. Make it mandatory that they go to school, if they get pregnant and have a child, give them day care centers so that they can get out and work or go to school, it has to be a thing that they have to know that "we are not going to support you and your children for the rest of your lives, you have to get it together yourselves." There has to be a support system for them. Social workers have the funkiest attitudes in the world, they have a God attitude towards recipients and its not fair and you feel like you're crawling.

The system has to support this affection that they need. The system has to give them something that's going to be very much more humanizing—and here comes that word again, humanizing—they have to feel their own worth, they have to regain respect, confidence and they have to know how to deal with their responsibilities. They have to be able to stand up on their own two feet and, if the system doesn't give them this along with day care centers and employability skills, these people will be here forever.

STATEMENT OF GANN WATSON, SOUTHEASTERN PUBLIC EDUCATION PROGRAM, COLUMBIA, S.C.

Ms. Watson. Good morning, Mr. Chairman.

My name is Gann Watson, and I am program associate for the Southeastern Public Education Program in Columbia, S.C. Ours is an organization which for the past 15 years has instigated and promoted educational reform in the South in the hope of achieving a public education system of high quality and full access for all children.

I appreciate the opportunity to speak before your Select Committee and hope that my comments will help broaden your views and increase your understanding of those issues which have a significant impact on children, youth, and families.

I understand that a component of your committee's task is to identify and address situations which affect the economic security of young people. My comments today will focus on a topic which is very closely linked to the economic well-being of youth; that topic is vocational training for students in high school.

In South Carolina we have a vocational system whose stated purpose is "to deliver vocational training and supportive services for meeting the identified needs of people and State manpower requirements."

The system was formally instituted in the mid-1960's to respond to two basic conditions: One, the fact that South Carolina did not have a well-trained, highly skilled labor force, and, two, the fact that about half of the students who graduated from high school chose not to continue their education but instead sought immediate entry into the job market.

Out of the response to these two situations grew the vocational education system as we know it today in South Carolina. A system which boasts more than 55 area vocational centers around the State, has a yearly expenditure of State/local funds amounting to almost $50 million and an additional $12 million in Federal dollars, and which serves about two-thirds of all of the students in grades 9–12 in South Carolina's public schools.

I have heard it said that South Carolina has one of the best vocational systems in the region in terms of facilities. But while adequate facilities are certainly essential to the efficient operation of any public education system, what is fundamental to that system is the content of the curriculum. In vocational education, curriculum is the kind of occupational training offered and how that training translates into employment skills for vocational graduates.

One way to measure and evaluate the effectiveness of the vocational education system is on the basis of how many students who complete their vocational training actually find jobs in fields related to that training. Following are a few job placement statistics for vocational completers in South Carolina.

In school year 1980–81, 87,288 students were enrolled in occupational training programs. In that same school year, 15,292 students completed their vocational training and were ready for placement. About 6 percent of these completers enlisted in the military and about 43 percent went into post-secondary education programs. The remaining 7,681 were available and waiting for employment. Of those 7,681, 2,568 found employment in the field for which they were trained. Less than a third found jobs in a field unrelated to the vocational skills they obtained, and about 18 percent were unemployed.

What we have here is an occupational training funnel. Poised above it is the vocational education system and waiting below is the job market pail. While a gush of students enter the mouth of the funnel in search of training that will enable them to compete for employment, only a narrow stream flows through the neck, and what emerges at the base of the funnel represents little more than a drop in the bucket.

To what extent, then, is the vocational education system really providing students with a direct link to employment in their chosen field? The above example suggests that it is to a very limited extent. More than 80,000 go in, but only 2,000-plus emerge and hit their target. Of what value was vocational education to those students who do not use the skills in the jobs they get, and more importantly, to those students who couldn't find jobs at all?

It is safe to say that the extent to which South Carolina's vocational system is contributing to the economic well-being of the majority of its students is not what it could be. What factors inhibit greater effectiveness of the voc-ed system in terms of job placement and program enrollment?

One, occupational training programs offered in the vocational education system in 1983 are, by and large, the same ones that were offered in the 1960's. Despite occupational demand projections which forecast to the contrary, we continue to offer training in auto mechanics, carpentry, brick masonry and cosmetology. And while these courses do provide a usable skill, the extent to which they contribute to actual employment is relatively small.

Furthermore, in some locations there is little connection between vocational training and the industrial makeup of a community. For instance, in the State's most highly concentrated resort, recreation and tourism area the school district's vocational system is teaching about 100 students how to repair lawnmowers, but only 14 students something about the hotel and motel industry.

Two, vocational enrollment in South Carolina continues to fall along traditional, gender-related lines. Machine shop programs which offer reasonable opportunities for employment have 97 percent male enrollment in 1982–83; and in the health occupations programs, which also provide comparatively high chances for employment, girls are over-represented by 94 percent. The significance of this continued sex stereotyping in vocational programs is that it serves to inhibit the boy who is interested in science and the helping professions, as well as the girl who demonstrates an interest in and talent for occupations which require a high degree of manual dexterity.

Despite the improvements that were noted in enrollment patterns in the years when grants were available to local districts to overcome sex stereotyping, in the past 2 years South Carolina has not allocated any moneys toward this effort. It is my suspicion that if the Federal requirement to maintain an office for sex equity within vocational education were eliminated that in South Carolina the job would be eliminated as well.

Three, the vocational education system continues to operate under the perception that it is a system for the academic underachiever. This perception is held by students, by parents, by business people and by educators. The significance of this perception is that it is absolutely self-perpetuating.

Four, vocational advisory councils are, for the most part, councils on paper only. This seems to be particularly true in the more rural areas of the state. Such situations suggest that very little input from the noneducation community is received for discussion in relation to how voc-ed is identifying and keeping up with the needs of people and manpower requirements at the local level.

Five, individual guidance and career counseling for vocational students is obtained by relatively few of them. High school students I have observed and talked with have indicated that they had seen a guidance counselor only once or twice by the time they were seniors. The above situations suggest that students make vocational enrollment decisions based primarily on personal familiarity rather than on knowledge and information obtained from the system.

Vocational educators, government officials, and representatives of business and industry all claim and decry the importance of high school students obtaining job-related skills by the time they graduate. Further, it goes without saying that the high school graduate in rural Calhoun County who learned a vocational skill and found a job which demanded and utilized that skill is contributing significantly to the economic security of herself, her family and the community.

Yet when the time comes to make bold new plans for improving education, little focus is placed on the vocational system. Since this is a system that can make a difference in the adult experiences of graduating students, it is imperative that we make substantive and continuing efforts to insure that it is succeeding at its intended purpose.

Thank you.

[Prepared statement of Gann Watson follows:]

PREPARED STATEMENT OF GANN WATSON, PROGRAM ASSOCIATE FOR THE SOUTHEASTERN PUBLIC EDUCATION PROGRAM IN COLUMBIA, S.C.

Good morning. My name is Gann Watson and I am Program Associate for the Southeastern Public Education Program in Columbia, South Carolina. Ours is an organization which for the past 15 years has instigated and promoted educational reform in the South in the hope of achieving a public education system of high quality and full access for all children.

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Out of the response to these two situations grew the vocational education system as we know it today in South Carolina. A system which boasts more than 55 area vocational centers around the state; has a yearly expenditure of state/local funds amounting to almost $50 million and an additional $12 million in federal dollars; and which serves about 2/3 of all of the students in grades 9–12 in South Carolina's public schools.

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One way to measure and evaluate the effectiveness of the vocational education system is on the basis of how many students who complete their vocational training actually find jobs in fields related to that training. Following are a few job placement statistics for vocational completers in South Carolina.

In school year 1980–81, 87,288 students were enrolled in occupational training programs. In that same school year, 15,292 students completed their vocational training and were ready for placement. About 60 percent of these completers enlisted in the military and about 43 percent went into post-secondary education programs. The remaining 7,681 (half of the 15,292) were available and waiting for employment. Of those 7,681, 2,568 (33.4 percent) found employment in the field for which they were trained. Less than a third found jobs in a field unrelated to the vocational skills they obtained, and about 18 percent were unemployed.

What we have here is an occupational training funnel. Poised above it is the vocational education system, and waiting below is the job market pail. While a gush of student enter the mouth of the funnel in search of training that will enable them to compete for employment, only a narrow stream flows through the neck, and what emerges at the base of the funnel represents little more than a drop in the bucket.

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It is safe to say that the extent to which South Carolina's vocational system is contributing to the economic well-being of the majority of its students is not what it could be. What factors inhibit greater effectiveness of the voc-ed system in terms of job placement and program enrollment?

(1) Occupational training programs offered in the vocational education system in 1983 are, by and large, the same ones that were offered in the 1960's. Despite occupational demand projections which forecast to the contrary, we continue to offer training in auto mechanics, carpentry, brick masonry, and cosmetology. And while these courses do provide a usable skill, the extent to which they contribute to actual employment is relatively small. Furthermore, in some locations there is little connection between vocational training and the industrial make-up of a community. For instance, in the state's most highly concentrated resort, recreation and tourism area the school district's vocational system is teaching about 100 students how to repair lawn mowers, but only 14 students something about the hotel and motel industry.

(2) Vocational enrollment in South Carolina continues to fall along traditional, gender-related lines. Machine shop programs which offer reasonable opportunities for employment have 97 percent male enrollment in 1982–83; and in the health occupations programs which also provide comparatively high chances for employment, girls are overrepresented by 94 percent. The significance of this continued sex stereotyping in vocational programs is that it serves to inhibit the boy who is interested in science and the helping professions, as well as the girl who demonstrates an interest in and talent for occupations which require a high degree of manual dexterity. Despite the improvements that were noted in enrollment patterns in the years when grants were available to local districts to overcome sex stereotyping, in the past two years South Carolina has not allocated any monies towards this effort. It is my suspicion that if the federal requirement to maintain an office for sex equity within vocational education were eliminated that in South Carolina the job would be eliminated as well.

(3) The vocational education system continues to operate under the perception that it is a system for the academic underachiever. This perception is held by students, by parents, by business people, and by educators. The significance of this perception is that it is absolutely self-perpetuating.

(4) Vocational advisory councils mandated by public law 94-482 are, for the most part, councils on paper only. This seems to be particularly true in the more rural areas of the state. Such situations suggest that very little in input from the non-education community is received for discussion in relation to how voc ed is identifying and keeping up with the needs of people and manpower requirements at the local level.

(5) Individual guidance and career counseling for vocational students is obtained by relatively few of them. South Carolina has a prevocational education component of the system which is designed to expose 9th and 10th graders to a variety of career areas and opportunities. Only 14 percent of the vocational student population, however, avail themselves of the pre-voc experience and the vast majority of pre-voc students are, for some reason, boys. High school students I have observed and talked with have indicated that they had seen a guidance counselor only once or twice by the time they were seniors. The above situations suggest that students make vocational enrollment decisions based primarily on personal familiarity rather than on knowledge and information obtained from the system.

Vocational educators, government officials, and representatives of business and industry all claim and decry the importance of high school students obtaining job-related skills by the time they graduate. Further, it goes without saying that the high school graduate in rural Calhoun county who learned a vocational skill and found a job which demanded and utilized that skill is contributing significantly to the economic security of herself, her family, and the community. Yet when the time comes to make bold new plans for improving education little focus is placed on the vocational system. Since this is a system that can make a difference in the adult experiences of graduating students it is imperative that we make substantive and continuing efforts to ensure that it is succeeding at its intended purpose.

Thank you.

TABLE 9

IV. A. ACHIEVEMENT OF FY 1981 ENROLLMENT AND SUPPLY GOALS**

Service Area/Agency	ENROLLMENT			SUPPLY (Placed in Field)		
	Actual	Projected	Difference(%)	Actual*	Projected	Difference(%)
AGRICULTURE						
VOC. ED. -	10,530	12,547		145	1,662	
TEC -	523	627		77	102	
TOTAL -	11,053	13,174	-16.1	222	1,764	-87.4
DISTRIBUTIVE ED.						
VOC. ED. -	4,952	5,329		544	1,165	
TEC -	2,241	2,813		151	277	
TOTAL -	7,193	8,142	-11.7	695	1,442	-51.8
HEALTH OCCUPATIONS						
VOC. ED. -	1,459	1,997		311	635	
TEC -	3,996	3,329		747	682	
TOTAL -	5,455	5,326	+2.4	1,058	1,317	-19.7
OCC. HOME ECONOMICS						
VOC. ED. -	2,037	2,200		52	443	
TEC -	362	105		13	14	
TOTAL -	2,399	2,305	+4.1	65	45	-85.8
BUSINESS AND OFFICE						
VOC. ED. -	44,110	32,615		845	3,847	
TEC -	17,013	17,518		896	1,128	
TOTAL -	61,123	50,133	+21.9	1,741	4,975	-65.0
TECHNICAL						
VOC. ED. -	-0-	-0-		-0-	-0-	
TEC -	9,452	12,089		561	748	
TOTAL -	9,452	12,089	-21.8	561	748	-25.0
TRADE AND INDUSTRIAL						
VOC. ED. -	24,200	27,150		1,243	5,435	
TEC -	12,680	11,242		823	932	
TOTAL -	36,880	38,392	-3.9	2,066	6,367	-67.6
GRAND TOTAL						
VOC. ED. -	87,288	81,838		3,140	13,187	
TEC -	46,267	47,723		3,268	3,383	
TOTAL -	133,555	129,561	+3.1	6,408	17,070	-62.5

Footnote #2.

*VOC. ED. - Estimates based on sample follow-up results.
Does not include placements in Higher Education.

**Enrollment figures reflect occupational courses only.

TABLE 11

IV. C. 1 VOCATIONAL EDUCATION FOLLOW-UP OF FY 1981 COMPLETERS/LEAVERS

SERVICE AREA	FY 1981 COMPLETERS AND LEAVERS	FY 1982 PLACEMENT FOLLOW-UP*													
		Pursuing Additional Education		Military and not in Labor Force		Available For Placement		Employed In Field		Employed Out of Field		TOTAL EMPLOYED		UNEMPLOYED	
		No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Agriculture	1186	536	45.2	83	7.0	567	47.8	151	12.7	151	12.7	302	25.5	265	22.3
Marketing and Distribution	1680	601	35.8	114	6.7	965	57.4	407	24.2	236	14.0	643	38.3	322	19.2
Health Occupations	308	169	54.9	19	6.1	121	39.3	47	15.3	26	8.4	73	23.7	47	15.3
Occupational Home Economics	528	211	40.0	38	7.1	280	53.0	66	12.5	50	9.5	116	22.0	163	30.9
Business Education	5697	2896	50.8	228	4.0	2572	45.1	972	17.1	737	12.9	1709	30.0	864	15.2
Trades and Industry	5893	2188	37.1	529	9.0	3176	53.9	925	15.7	1152	19.5	2077	35.2	1099	18.7
TOTAL	15292	6601	43.2	1011	6.6	7681	50.2	2568	16.8	2352	15.4	4920	32.2	2760	18.0

* Sample Follow-Up Results Expanded to Total Completer and Leaver Count.

#6 #7

Footnote #3 #5 #4

VOCATIONAL EDUCATION SCHOOL ENROLLMENT, BY SEX
1982 - 83 SCHOOL YEAR

June 1983

SOUTH CAROLINA DEPARTMENT OF EDUCATION

Dr. Charlie G. Williams, State Superintendent

Mr. Sidney B. Cooper, Deputy Superintendent for Instruction

Dr. Moody Oswald, Director, Office of Vocational Education

Dr. John C. Smiley, Chief Supervisor, Ancillary Services Section

FY 1976 TO FY 1982

. E. CODE	COURSE NAME	1976-77 ENROLLMENT Total	1976-77 ENROLLMENT Female	1976-77 ENROLLMENT % Female	1982-83 ENROLLMENT Total	1982-83 ENROLLMENT Female	1982-83 ENROLLMENT % Female
	DISTRIBUTIVE EDUCATION (continued)						
04.16	Petroleum	61	5	8%	39	6	15%
04.17	Real Estate	36	13	36%	17	7	41%
04.18	Recreation & Tourism	98	46	47%	42	15	36%
04.19	Transportation	123	28	23%	57	30	53%
04.20	Business Services	--	--	--	79	54	68%
04.21	Business Ownership	--	--	--	78	31	40%
04.22	Gen. Marketing	1,011	645	64%	452	297	66%
04.9900	Sales and Marketing, Other	116	43	37%	294	211	72%
		5,268	3,281	62%	4,134	2,718	66%
	HEALTH OCCUPATIONS						
07.0101	Dental Assisting	--	--	--	4	4	100%
07.0302	Practical Nursing	421	412	98%	118	112	95%
07.0303	Nursing Assistant	308	291	94%	152	147	97%
07.99	Health Occupations	674	611	91%	948	878	93%
		1,403	1,314	94%	1,125	1,141	93%
	CONSUMER & HOMEMAKING						
09.0101	Advanced Consumer & Homemaking	15,935	14,867	93%	11,145	9,301	83%
09.0102	Child Development	4,689	4,211	90%	3,231	2,663	82%
09.0103	Clothing & Textiles	5,540	5,177	93%	3,385	3,010	89%
09.0104	Consumer Education	2,733	2,037	74%	1,485	699	47%
09.0106	Family Life Education	9,017	5,720	63%	4,911	3,288	67%
09.0107	Foods & Nutrition	5,904	4,892	83%	6,064	4,104	68%
09.0109	Housing & Home Furnishing	3,064	2,750	90%	1,305	1,091	84%
09.0191	Human Sexuality	547	360	66%	829	548	66%
09.0192	Parenthood Education	--	--	--	2,779	2,120	76%
09.0198	Experimental	429	250	58%	349	213	61%
		47,858	40,264	84%	35,483	27,037	76%
	OCCUPATIONAL HOME ECONOMICS						
09.0201	Child Care Services	634	627	99%	564	530	94%
09.0202	Clothing Services	86	81	94%	90	90	100%
09.0203	Food Services	1,302	854	66%	1,102	724	66%

VOCATIONAL EDUCATION ENROLLMENT COMPARISON
FY 1976 TO FY 1982

		1976-77 ENROLLMENT			1982-83 ENROLLMENT		
E. CODE	COURSE NAME	Total	Female	% Female	Total	Female	% Female
	TRADES & INDUSTRIAL (continued)						
7.0601	Dry Cleaning	1	0	0%	--	--	--
7.19	Graphic Communications	1,118	574	51%	969	569	59%
7.2302	Machine Shop	1,114	29	3%	1,054	44	4%
7.2304	Metalwork & Fabrication	4	0	0%	29	2	7%
7.2305	Sheet Metal	136	3	2%	157	3	2%
7.2306	Welding	1,635	24	1%	1,484	47	3%
7.2601	Barbering -	--	--	--	31	1	3%
7.2602	Cosmetology	982	934	95%	1,303	1,230	94%
7.2800	Public Service Occupations	7	7	100%	--	--	--
7.2900	Quantity Food Occupations	23	11	48%	--	--	--
7.2903	Meatcutter	8	0	0%	--	--	--
7.2904	Waiter/Waitress	16	15	94%	--	--	--
7.3100	Small Engine Repair	781	17	2%	578	9	2%
7.3300	Textiles	676	197	29%	410	92	22%
7.3302	Tailoring	135	85	63%	74	72	97%
7.3399	Industrial Sewing	1,912	1,814	95%	1,640	1,537	94%
7.3601	Cabinetmaking	171	13	8%	192	8	4%
7.99	T & I, Other (Experimental)	252	74	29%	357	43	12%
		27,159	4,490	16%	22,694	4,657	20%
	PREVOCATIONAL						
9.0100	Prevocational	21,310	4,350	20%	12,550	2,207	18%
	INDUSTRIAL ARTS						
9.0400	Industrial Arts	5,645	677	12%	4,609	718	16%
	SUMMARY						
	Agriculture	12,417	1,175	9%	8,662	1,084	13%
	Distributive Education	5,268	3,281	62%	4,134	2,718	66%
	Health Occupations	1,403	1,314	94%	1,225	1,141	93%
	Consumer & Homemaking	47,858	40,264	84%	35,483	27,037	76%
	Occupational Home Economics	2,184	1,716	79%	1,829	1,401	77%
	Office Occupations	30,380	23,928	79%	22,295	17,253	77%
	Trades & Industrial	27,159	4,490	17%	22,694	4,657	20%
	Prevocational	21,310	4,350	20%	12,550	2,207	18%
	Industrial Arts	5,645	677	12%	4,609	718	16%
	TOTAL	153,624	81,195	52%	113,481	58,216	51%

STATEMENT OF ROGER E. BIAMBY, EXECUTIVE DIRECTOR, HAITIAN AMERICAN COMMUNITY ASSOCIATION OF DADE COUNTY, INC.

Chairman MILLER. Thank you.

Roger.

Mr. BIAMBY. Good morning, Mr. Chairman, other members of the committee. Let me take this opportunity to thank you for allowing me to speak before you today.

My name is Roger E. Biamby, executive director of the Haitian American Community Association of Dade County, Inc. [HACAD].

HACAD is the only Haitian social service agency serving primarily Haitians. Presently we provide assistance to the Haitian community in the areas of legal matters related to housing, employment services, English as a second language [ESOL], emergency food and shelter and general social services.

In fact, I cannot in 5 minutes enumerate the various problems and serious issues HACAD is facing; however, I am taking this opportunity to present some highlights for your consideration.

It is estimated that approximately 60,000 to 70,000 Haitians reside in south Florida. Little Haiti, an enclave within Edison-Little River, represents the largest community; 25,000 to 35,000 Haitians live in that section of Miami. Other Haitian communities are found in Belle Glade, Immokalee, Delray, Deerfield, Homestead, and other predominantly agricultural areas of south Florida.

Unemployment remains the most serious problem facing Haitians. A recent survey conducted by HACAD in 1982–83 reveals that over 60 percent do not have stable, permanent jobs and over 90 percent are looking for work; more than one-half of the latter category earn less than $145 a month per person. Yet very few Haitians receive any kind of government or private assistance.

Housing in Little Haiti is overcrowded and is in deteriorating conditions. U.S. census figures show a population increase of 27 percent in a decade—from 29,000 in 1970 to 35,000 in 1980. Since 1980, however, the population has increased significantly.

A planner for the city of Miami's planning department estimated at "over 40,000 people, all squeezed into about the same number of houses as existed in 1970." Most of the structures were built in the 1920's. HACAD's two attorneys are in court practically every day litigating landlords on matters dealing with housing code violations, illegal withholding of clients' security deposits.

Mr. Chairman, in the past year, our two staff attorneys recovered through litigations over $30,000 in security deposits illegally held by the landlords, and as immigrant groups, we are being taken advantage of by the established community. This year alone, close to $20,000 has already been recovered. The fact of the matter is that the Haitian community still does not know its rights. It is a gradual process, and we are helping with this process.

Discrimination is widespread. Health problems are usually used as an excuse to deny Haitians jobs. The latest example is the unfair classification of Haitians as a nationality by the Center for Disease Control as a high risk group in the Nation's No. 1 health problem, namely AIDS.

This is having also a serious impact on the Haitian children when they come to the public school system. They are seriously psychologically affected. Peer pressure is tremendous. No one wants to associate with the Haitians. This issue has served only to exacerbate an already explosive situation in the schools. Haitian children at present refuse to identify themselves as Haitians.

The parents are unable to assuage their fear. However, the cooperation of Paul Bell and T. Greer, associate superintendents of the Dade County Public Schools, represents a great support to the Haitian parents. We hope with his concern that eventually many of our children's problems will be solved.

There is a very high birth rate in the Haitian community. Since January 1982 to date, approximately 21 percent of the recorded births at Jackson Memorial Hospital were to Haitian mothers. There is a dire need for a family planning program in this community.

Day care and child facilities are practically nonexistent. Many Haitian mothers are willing to work but such facilities are practically nonexistent. Many would like to go to school and learn skills, but they are unable to pay for private day care. They would like to become contributing members of their respective households.

The Haitian children are all black. They are classified as such, but the Hispanic children have a special position in the school system. The system hires the appropriate number of teachers based on the population. Yet though Haitian children comprise 3,000 to 4,000 of the children in the public school system, the language barrier must be recognized, and they must provide some additional guidance to those students; otherwise they will not be able to function adequately in the school system.

The after-school program is a much needed program for the Haitian children. None exists at present to the best of our knowledge for Haitian children in elementary, junior high and high schools. In the past, intermittent fundings were provided to certain schools for remedial education on math and science. A more consistent approach must be adopted to enhance their performance.

Health care is an area where a lot of attention must be focused, especially preventive health care. Only one primary health clinic funded by HHS operates in this community. Jackson Memorial Hospital receives a very large portion of the Haitian population. It is remotely located from the Haitian community and the quality of care provided to Haitians must be questioned. Though they do not cease to cry out for financial assistance to Washington, and they have indeed received such allocation, but much improvement is needed in the delivery of quality health care.

Last Saturday a Haitian woman went to Jackson Memorial. She complained to the emergency room that she was about to have her baby. The doctors told her she was not ready. They called the police and forcefully had her removed from the premises. Two hours later the infant died.

Mr. Chairman, and members of the committee, I could go on, but I think the Haitian community represents the Nation's newest immigrant. I think efforts must be made by Washington. Dade County, Florida, cannot do it alone. We need your assistance.

Thank you.

[Prepared statement of Roger E. Biamby follows:]

PREPARED STATEMENT OF ROGER E. BIAMBY, EXECUTIVE DIRECTOR, HAITIAN AMERICAN COMMUNITY ASSOCIATION OF DADE COUNTY, INC. (HACAD)

I want to thank you Mr. Chairman and other members of the Committee for inviting me to speak before you today. My name is Roger E. Biamby, Executive Director of the Haitian American Community Association of Dade County, Inc. (HACAD).

HACAD is the only social service agency serving primarily Haitians. Presently we provide assistance to the Haitian community in the areas of legal matters related to housing, employment services, English as a Second Language (ESOL), emergency food and shelter and general social services.

In fact, I cannot in five minutes enumerate the various problems and serious issues HACAD is facing, however, I am taking this opportunity to present some highlights for your consideration.

Population

It is estimated that approximately 60,000 to 70,000 Haitians reside in South Florida. Little Haiti, an enclave within Edison-Little River, represents the largest community. 25,000 to 35,000 Haitians live in that section of Miami. Other Haitian communities are found in Belle Glade, Immokalee, Delray, Deerfield, Homestead and other predominantly agricultural areas of South Florida.

Unemployment

Unemployment remains the most serious problem facing Haitians. A recent survey conducted by HACAD in 1982–1983 reveals that over 60 percent do not have stable, permanent jobs and over 90 percent are looking for work—more than one half of the latter category earn less than $145 a month per person. Yet, very few Haitians receive any kind of government or private assistance.

Housing

Housing in Little Haiti is overcrowded and is in deteriorating conditions. United States Census figures show a population increase of 27 percent in a decade—from 29,000 in 1970 to 35,000 in 1980. Since 1980, however, the population has increased significantly. A planner for the City of Miami's Planning Department estimated at "over 40,000 people, all squeezed into about the same number of houses as existed in 1970". Most of the structures were built in the 1920's. HACAD's two attorneys are in court practically every day litigating landlords on maters dealing with housing code violations, illegal withholding of clients' security deposits.

Discrimination

Discrimination is widespread. Health problems are usually used as an excuse to deny Haitians jobs. The latest example is the unfair classification of Haitians as a nationality by the Center for Disease Control as a high risk group in the nation's number one health problem namely A.I.D.S.

Haitian children in the Dade County Public Schools are also psychologically affected. Peer pressure is tremendous. The A.I.D.S. issue has served to exacerbate an already explosive situation in the schools. Haitian children at present refuse to identify themselves as Haitians. Their parents are unable to assuage their fear. However, the cooperation of Paul Bell, the Associate Superintendent of the Dade County Public Schools, represents a great support to the Haitian parents. We hope with his concern that, eventually, many of our children's problems will be solved.

High birth rate

Since January 1982 to date, approximately, 21 percent of the recorded births at Jackson Memorial Hospital were to Haitian mothers. There is a dire need for a family planning program in this community.

Day care/child care facilities

Many Haitian mothers are willing to work but such facilities are practically nonexistent. The need exists for day care and child care facilities to allow women to work and to learn vocational skills so that they can become contributing members of their respective households.

After school program

It is a much needed program for the Haitian children. None exists at present to the best of our knowledge for Haitian children in elementary, junior high and high schools. In the past, intermittent fundings were provided to certain schools for remedial education on math and science. A more consistent approach must be adopted to enhance their performance. HACAD will attempt to initiate such program with the support of the Dade County School Board. But the school system must be provided with additional resources.

Health care

Attention must be focused on preventive health care. Only one primary health clinic funded by HRS operates in this community. Jackson Memorial Hospital receives a very large portion of the Haitian population. It is remotely located from the Haitian community and the quality of care provided to Haitians must be questioned. Though, they do not cease to cry out for financial assistance to Washington and they have, indeed, received such allocation but much improvement is needed in the delivery of quality health care.

Mr. Chairman and members of the Committee, I could go on and on highlighting the different problems faced by the Haitians in this community. For further reference, I have enclosed copies of surveys done in the Haitian community in Miami as well as copies of various newspaper articles related to Haitians issues. The fact of the matter is that the children are directly and indirectly affected by problems confronting their parents.

Haitians are the poorest of the poor in South Florida. They need your help so that our children can be properly enculturated and can become productive members of the American society while retaining their cultural identity.

STATEMENT OF J. MICHAEL CUPOLI, M.D., DIRECTOR, SECTION ON CHILD DEVELOPMENT, DEPARTMENT OF PEDIATRICS, UNIVERSITY OF SOUTH FLORIDA

Chairman Miller. Thank you.

Dr. Cupoli. Mr. Chairman, members of the committee, I am tired of hearing depressing news this morning. I also give you a document that is full of depressing news. I would like to review that document very quickly so there might be a minute to give some encouraging news.

As bad as the literature is about child abuse and neglect, the real life story is worse than what is on paper. I have called all over the country to people I have worked with in Boston, Denver, Washington, Florida. None of them had real numbers, but we have a lot of educated guesses. And I will try to give you my own experience.

The jails are full of people who were abused as children. Most data show that 80 to 90 percent of those in jail were abused and neglected as children. Seventy to 80 percent of people in juvenile detention and delinquency homes have been abused or neglected as children.

Seventy to 80 percent of those people had learning disabilities. How many educational problems and learning problems came from being abused or neglected? More than 60 percent of children who are called mentally retarded don't have a diagnosis that adequately explains their retardation, even in those clinics who spend much time seeking a cause. We simply don't know why they are retarded.

Yet we know from neglect and from the clinics that 40 to 50 percent of the kids who are retarded for no known reasons are retarded because of poor language skills, often because of the environmental deprivation that others here have mentioned. Probably 25 percent of children with cerebral palsy acquired cerebral palsy outside of the birth time, during the first year of life. We think as many as 25 to 50 percent of children who are mentally retarded, were physically abused.

What is the impact on our educational system? You know better than I the cost of special programs for people who are mentally retarded, emotionally handicapped, and learning disabled. A large percentage—I have found in the literature 25 to 50 percent of those children—were abused.

I have heard today people talking about the impact of the regional perinatal program in Florida. The average cost for those children is $10,000 for their first 3 weeks of life. Medicaid pays $100 for the rest of the 50 weeks of their first year.

We try to follow those children, but we do not have funds for that. We tend to sort of do it anyway. I am fortunate to be in a State program, and what I get paid is constant so I can see who I want to see. Unfortunately, others don't want to see them.

I get to see the parents. I get to see people who don't have jobs because they are learning disabled. I get to see people who don't have jobs because of physical deformities. I get to see people who have bad children, and I said "bad" in quotations, because they don't know how to bring up children, because that is how they were brought up.

During the cumulation of the morning I am close to tears because I also see the dead kids. We all kind of sighed when we heard about the one Haitian today and the numbers of Haitians who are dying in our country due to poor medical care. Yet, more than 2,000 children a year die in the United States of child abuse. I see four or five a year every year, year after year, just in the city of Tampa. The bulk of those are under the age of 2.

A concern that came up repeatedly today and probably isn't in my testimony, written testimony: I am beginning to see that private-for-profit hospitals are taking the paying people from our public hospitals and county hospitals. These hospitals used to take as a community responsibility the care of indigent people.

You take the paying patients, as unfair as that is, from other hospitals, and when the Government cuts back State and Federal funds to care for indigent, the result is more medically poor people, people who have poor pregnancies, people whom we have to treat over the next 20 or 30 years of their lifespans.

When we look at the cost of what we don't do for our children, we see that it is very expensive. The numbers for prevention are so astounding that I don't know if you will believe them, but one child who has been severely damaged by a head blow who is in a vegetative state costs the State during that child's life span $400,000. That would pay for two home visitors for 10 years, and each of those home visitors in my situation see 50 to 100 kids a year, and they do it well.

What works in education? The education of child care works. You were very concerned about teenage pregnancy. The rate of teenage pregnancy went down 350 percent in Orlando simply by teaching children an awareness of contemporary medical problems. It wasn't sex education. Many people are scared of that. If we just taught 18-year olds what 2-year olds were like, we would probably have a lot less pregnant 18-year olds.

What works legally? Every case of criminal abuse and sexual abuse in Pinellas County is reviewed by a protection team. We keep a lot of people out of jail and out of court just by having people who are experts in children helping the State attorney make decisions about what we can do so the juvenile court isn't so intrusive to children.

What works medically? We have a group of programs in the county I am very proud of. We have seen 50 children with failure to thrive, none of whom have failed to thrive again. We have kept them out of the hospital and documented that we have saved $2,000 per child in hospital costs.

We have in Tampa a Rainbow House that deals with known child abuse. That is a lovely program, as prejudiced as I am. We use elderly volunteers, foster grandparents to take care of the kids because the mothers themselves are emotionally deprived, and they need some help from the grandmothers and grandfathers.

Institutionally we have really done poorly with the children of this country. You have heard that this morning. One of the privileges of being a physician is that I get to see how individuals cope in impossible situations. You need to know that child abusers were abused themselves, but more importantly in spite of that, they love their children. Think of yourself in terms of a 19-year old who comes to me whose children has severe bruises, and she breaks down when I ask her about it, and she tells me that she was fearful for her child.

"Well, why did you come? Were you afraid you were going, that you were going to be arrested?" Well, it is not true that she was going to be arrested, but she thought she was. Over and over again I see people who at great risk to themselves come to the emergency room "knowing" that they are going to go to jail. They don't, by the way, but they have that perception. Yet they bring their kids.

There is no question that they love their kids. The problem is we have made them nonpeople, called them abusers and neglectors. And that sounds bad. And the people of whom we have heard about this morning who are just completely overwhelmed, stuck and don't know where to go. We are not dealing very well with the poor. Hospitals are making money on the insured and rich, yet poor people are getting no or little care.

To put it in perspective, 10 to 30 percent of children who are abused physically, if it happens again, they die. If I had a choice between my child having meningitis and being the victim of repeated abuse, I would be safer having meningitis. He also would be safer than the kids who fail to thrive, who fail in school and fail into adulthood. The recidivist rate with good care, now, somebody who knows what they are doing, is less than 5 percent.

And you know there are a lot of people across the country who know how to care for these people. It is caring, being with them for a year or so as support people and knowing how to support. It is not easy, but we know how to do it, damn it. We have known how to do it for 20 years. And we are not doing it. It is because people are afraid if they pay taxes it is going to come out of their pockets.

One final thing, because it was brought up before. There are a number of recommendations in the back of my testimony. One that I think that is fearful for some people. Corporal punishment means that the community as a whole has decided that we should show our children that it is appropriate to hit kids. Many of us here have been hit as children. Many of us have been humiliated as children. We say in the State of Florida that there isn't a good educational course in child development. Well, there is a damn good one. It is, "when all else fails, hit the little bastard." And our kids who never have had any experience raising children of their own see the experts hitting them and their classmates.

I believe in discipline. Discipline comes from the person knowing what is good and what is wrong. There are ways to discipline. People who train animals know the best way. They reward them. They don't hit even dolphins anymore.

So I think it would be very important and something that would be very important that there be guidelines that corporal punishment not be shown as the example to our children, that there be alternatives to corporal punishment, and those alternatives reward us perhaps in financial or tax ways.

I think it is very difficult for me to say what those alternatives are, but as long as we fall back on suspending kids and hitting kids, we are going to continue to have kids drop out. And you have heard all that. I remember being hit once in school. And I still remember it. And I think that it was a very humiliating experience. I would like to think it was an accident.

The fact is it makes an incredible impression on children. Children want to do right. We ought to build on that.

Thank you for your patience.

[Information submitted by J. Michael Cupoli follows:]

The Consequences of Child Abuse by J. Michael Cupoli, M.D., F.A.A.P., Associate Professor, Pediatrics Director, Section of Child Abuse, University of South Florida College of Medicine

We are guilty
of many errors and many faults
but our worst crime
is abandoning the children,
neglecting the fountain of life.
Many of the things we need
can wait. The child cannot.
Right now is the time
his bones are being formed, his
blood is being made, and
his senses are being developed.
To him we cannot answer
'Tomorrow.'
His name is 'Today.'

Gabriela Mistral

LEADING CAUSES OF DEATH IN CHILDHOOD

Ages 1-4

Rank		
1	Accidents	(Unknown % due to Abuse, Neglect)
2	Congenital Malformations	
3	Influenza and Pneumonia	
4	Homocide	(All due to Abuse)

Ages 15-19

1	Accident	(Unknown % due to Abuse, Neglect)
2	Malignancy	
3	Homocide	(Unknown % due to Abuse, Neglect)
4	Suicide	(Unknown % due to Abuse, Neglect)

CHILD ABUSE IN THE UNITED STATES

	Published Numbers	Estimates of "Real" Numbers
Abuse	2 million	3 - 5 million
Sexual Abuse	100,000	Equal number to physical
Total	2 - 3 million	5 - 8 million
Estimated Rates	10 - 20/1000	

FLORIDA RATES

Number of Children	2,414,000
Number of Abuse Reports	85,466
"True" Abuse/Neglect	approximately 43,000 reported
National Incidence (1981)	7.6/1,000
Florida Incidence range 17.5(urban) - 27.4 (rural)	18.2/1,000
Serious Neurological Damage to Children (excluding death)	128 children
Serious Burns, Scalds	564 children
In Foster Care Due to Physical Abuse	1,880 children
Length of Stay in Foster Care (1982) Majority are under 5 years of age.	3.3 years

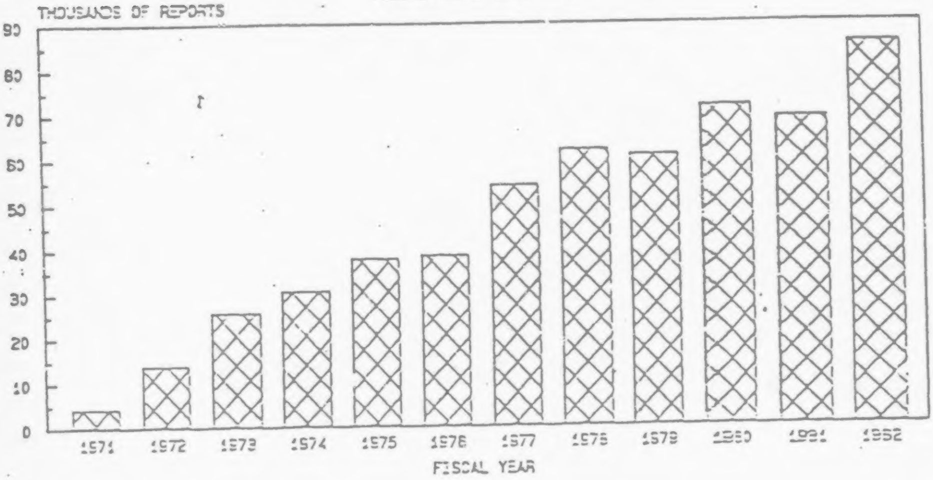
70% of all sex offenders have been themselves victims of sexual assault or sexual trauma.

65% of children admitted to state mental hospitals in 1978 had histories of abuse and neglect.

Thanks to Jim Jolly, Director of Child Abuse Registry, Florida Department of Health and Rehabilitation Services.

FLORIDA

REPORTS OF CHILD ABUSE AND NEGLECT
FISCAL YEARS 1971-1982



Fiscal Year	Children Reported	Percent Change from Previous Year		
1971	4,225	5.6	816.1	
1972	13,983	231.0		511.2
1973	25,853	84.9		
1974	30,695	18.7		
1975	37,958	23.7		
1976	38,704	2.0		
1977*	54,229	40.1	57.6	
1978*	61,984	14.3		
1979*	60,840	(1.8)		
1980*	71,522	17.6		
1981	68,902	(3.7)		
1982*	85,466	24.0		

*calendar year

The mistreatment of children in the United States produces incredible human and financial burdens. Although little of this information is new, I hope that this review of the known effects will have a cumulative effect. The human suffering here documented is usually described from the prospective of children suffering, but you must widen the scope of your understanding to see child abuse as a major problem for adults in our country.

The physical pain and physical limitations caused by direct injury to children is astounding but at least concretely understood and documented. The emotional and mental damage that results from abuse and neglect of children is less well understood and is very difficult to document as the true effects may not be manifested until the next generation. More and more therapists are discovering that the final effects of abuse are seen in the children and grandchildren of the abused child.

PHYSICAL EFFECTS

The term maltreatment of children refers to the fact that millions of children in the United States are victims of physical abuse, sexual abuse, incest, and emotional abuse. The neglect of children—the failure of caregivers to provide adequate food, shelter and medical care—also results in severe handicaps.

Physical abuse can be manifested by medical evidence of fractures, bruising and burns, head injury, abdominal injury, and failure to thrive. These physical injuries will briefly be discussed.

Physical abuse, the trauma of our children by parents, results in fractures of the skull, arms, legs, and ribs. These fractures often require hospitalization and a minimum of 6-8 weeks of treatment. Many of these children—perhaps 20 percent have chronic handicapping conditions throughout their adult lives. Such trauma is often (25 percent) associated with brain injury (Solomen, 1979). As many as 20 percent of injured infants have neurological damage severe enough to produce life-long disability. Cerebral palsy refers to brain injury which causes permanent motor weakness or spastisity. Outside of the newborn period, the most common cause of cerebral palsy is child abuse. Nelson, Ellenburg (1978) stated that 25 percent of cerebral palsy in the United States was caused by trauma. Mackeith (1974) in England was more specific, saying that 25 percent of all cerebral palsy was due to child abuse. Diamond & Lauds noted that 10 percent of cerebral palsy was caused by abuse, but 15 percent of cerebral palsy children had abuse occur after the diagnosis of cerebral palsy. Their study showed that 43 percent of their cerebral palsy clinic children had had an abuse episode!

Neurological damage also can cause enough loss of brain function for a child to be mentally retarded. More than 60 percent of all retarded citizens are retarded due to "unknown causes". At least half of these "unknown" cases are due to neurological damage from abuse. Gil (1970) in one study showed 29 percent of abused children are developmentally disabled. Elmer (1977) noted that 30 percent had central nervous system damage, 52 percent had earlier I.Q. scores less than 80, of which 42 percent continued to be delayed. Martin (1974) noted 33 percent of abused/neglected children had I.Q.'s less than 80. Sandgrund (1974) noted a developmental delay 8-fold higher in abused children then in his control. When one also includes the great amount of children who are functionally retarded due to neglect or environmental deprivation, then we can say that more than half of all retarded children (about 2 percent of all children) are retarded due to abuse or neglect. What happens to these children? Most grow up. Many grow up to be retarded or marginal adults requirng state aid or support.

A special form of brain damage needs further description. Dr. Caffey (who in 1946 described child abuse) described the "shaken infant syndrome" (Caffey, 1977). Infants usually under 18 months are held under the arms and shaken so vigorously that the brain is whipped back and forth in the skull causing bleeding. In Tampa at least one child per year is known to die from this injury. We have no idea how many retarded children acquired their retardation after being shaken as infants. Dr. Caffey surmised that this syndrome may be the most common cause of mild mental retardation and of mild motor retardation. "Mild" refers to degree of retardation. It in no way refers to the impact on child or family.

A third form of injury to children are those injuries caused by blows, usually punches to the abdomen. In the past 6 years, I have treated 5 children with severe abdominal injury inflicted by a caretaker. Two infants died from abdominal injuries. Two required surgery and survived, but with severe feeding problems. One did not require surgery, but was hospitalized for a prolonged period of time. Abdominal trauma is the second most common cause of death in abused children. Often there are no bruises on the abdomen, so the internal injuries are hidden causing fatal delay in diagnosis and treatment.

Another heartbreaking form of abuse is the intentional burning or scalding of children. 16 percent of scalded children die (Feldman, 1978). We know from the literature that 50 percent of children with severe burns have severe mental and emotional illness as adults. I would expect those who were intentionally burned to be disproportionally represented in the mentally ill group. The human cost is extreme pain and suffering. The financial cost is overwhelming for the family as well as for society. 50-60 percent of children with burns admitted to our hospital last year were burned intentionally by an adult, most under 3 years of age.

LEARNING AND BEHAVIORAL EFFECTS

Learning problems

Non-specific learning problems are found in a large number of abused children, even those children without any demonstrable neurological damage. The most consistent finding is that these children have poor social and poor language skills.

Other papers show this delayed development begins frightfully early. Appelbaum (1977) demonstrated effects as early as 4 months. I have seen failure to thrive infants demonstrate motor and developmental delays as early as 8 weeks (Cupoli, Hallock, Barness, 1980). Some of this delay is treatable. Koski and Ingram (1977) showed that one-third of the abused children studied under 30 months of age were developmentally delayed. Some of this delay was due to poor social skills.

The phrase "developmental delay" has a sterile quality, but when seen in individuals, the quality of need is more forceful. I have seen patients fail one, two, or three grades of school. They have poor self image, often resulting in hyperactive, acting out, behavior. Many fail to complete school. "Developmental delay" is easy to confirm by the I.Q. score, however, the speech delays and behavior maladaptations can be more destructive to a good outcome, and are more difficult to closely define. We find that stressed children, especially abused and neglected children, tend to lose verbal abilities first, and re-establish verbal skills last along the road to recovery. This can be devastating in that the first 3-4 years of school is based primarily on verbal skills. Freidrich, et al., (1983), Martin (1974), Gaensbauer and Saub, all note this delay in expressive language.

Behavior problems

Behavior problems, usually described as hyperactivity, distractability, or poor impulse control is a consistent finding in child abuse studies. Friedrich (1983) emphasizes the distractability of these children. Blumberg (1979) emphasizes the acting-out and aggressive behavior of both abused and handicapped children. Unfortunately, this aggressive behavior frequently is self-distructive, resulting in a higher incidence of suicide, suicide behavior, and self-mutilation. This is a little-known result of abuse (Green, 1978).

Problems in adults

Our experience in school problem and home behavior clinic is that these I.Q., behavior and emotional problems are not limited to children. These abused and neglected children grow up. We all have a vague notion that abused children grow up to be abusing adults. This is true for some. But far more are debilitated by self-doubt. They have no early models to fall back on. They have had no experience of good parents. They do not know how to parent. They also are fearful of discipline, fearful they will lose control. As a result, their children have poor understanding of limits, do not have self-discipline, and tend to fail in school for at least two reasons. Most obviously they fail due to the I.Q., behavior and speech problems described above. Less obvious and not well reported is that children whose parents were abused as children have severe discipline or control problems at home and at school, since their parents are fearful of taking control. This acts across generations. We have all seen and reported 3-4 generations of physical abuse, but we are just now becoming aware of 3rd and 4th generations of school failures due to poor parenting skills and a particular form of emotional lacuna that interfers with the child "growing up". These 2nd and 3rd generation children present to me as hyperactive or as delayed, or as severe behavior problem. I have seen several families with children failing in school directly due to mother's delayed reactions to seeing her mother abused.

Failure to thrive

Five percent of our pediatric population are small enough to be diagnosed as failure to thrive. Outside of the United States this is caused by lack of available food, but in the United States the most common cause of failure to thrive is isolation of the mother with emotional deprivation of the mother, and/or poor feeding skills. In the past "maternal deprivation" has implied guilt on the mother's part, but now we understand "maternal deprivation" to refer to the mother as isolated and emotionally deprived (Cupoli, Hallock, Barness, 1980).

The short term effects of failure to thrive include growth failure for the child (Fitzhardinge & Steven, 1972), separation of mother and child, severe self-image problems in the mother, and worsening of her depression. The short and long term effects on the child include mental retardation, developmental delay, delayed expressive speech (Chase & Martin, 1970), (Klein, Forbes & Nader, 1975 and Martin, 1973), growth retardation, depression, and poor inter-personal relations reaching into adult life (Hufton & Oates, 1977).

The ultimate outcome is based on the severity of the weight loss, the age of the child, and the delay in initiating weight gain.

Five forms of non-organic failure to thrive are described (Evans, Reinhart & Succop, 1970 and Cupoli, Hallock & Barness, 1980). The form of failure to thrive associated with an angry abusive mother is most severe, has the worst prognosis and probably should be treated by early termination of parental rights. Non-organic failure to thrive due to chronic maternal depression, with a long history of repeated loss, has a poor prognosis and requires long-term therapy. However, failure to thrive due to acute maternal depression, or due to maternal anxiety, can be treated within a short period of time. Those who fail to thrive due to parental inexperience are also treatable with short-term intervention. Families and mothers at risk for failure to thrive can easily be predicted and prevented. Early diagnosis and treatment markedly decreases the negative effects. Yet, the effects of delay of treatment are serious.

One-third have mental retardation, one-third have learning disabilities, and one-half have severe behavior disturbances into adulthood (Hufton & Oates, 1977). Their physical growth is retarded in half of the children (Fitzhardinge & Steven, 1972).

In spite of our knowledge of the prevention, diagnosis and treatment of failure to thrive, and in spite of our knowledge of the poor outcome, very few programs exist to prevent and treat this disease.

SEXUAL ABUSE

Sexual abuse of children has been shown to have all the developmental (cognitive) and behavioral problems as other forms of abuse. They also have specific problems related to the sexual nature of the abuse, and related to the awful insult to the child's developing trust (Mrazek, 1980).

The incidence of sexual abuse of children is not known. Kempe (1977) thinks it is just as common as physical abuse and failure to thrive. Scherzer and Laia (1980) document that 41 percent of child abuse cases in Baltimore were reported as sexual abuse in 1976, and 31 percent were so reported in 1978. In 1982, 234 children came to the Tampa General Hospital emergency room with some form of sexual abuse. This is not just an adolescent problem; many infants, toddlers and preschool children are molested. Approximately one-third (⅓) of sexual abuse cases occur under the age of 10—eleven percent (11 percent) of the cases are boys. Silbert & Pines (1981) noted that sexual child abuse was an "antecedent to prostitution", 60 percent of prostitutes were sexually exploited, 70 percent reported their choice of prostitution as a life style was based on their own sexual exploitation. The authors state, "The evidence linking juvenile sexual abuse to prostitution is overwhelming".

Kempe (1977) also noted sexual abuse to result in prostitution, sexual dysfunction, and marital discord.

I have seen encopresis in adolescents, run-away behavior, drug use, depression, school failure and suicide as the immediate effects of sexual abuse or incest. The delayed impact on future family, future parenting and future sexual function is well described but difficult to predict (Connell, 1978).

I have heard many speakers and read many authors who confirm the mental, behavioral and sexual impact of incest and sexual abuse upon the victim. Only recently have we all begun to read that incest can be successfully treated. Incest has been treated in the past as an assault/victim relationship, we are learning that incest is part of a complex, failing family relationship that includes mother and often the siblings. Giarretto, (1980) and others have reported wonderful results in the treatment of 600 families at least 10 hour of therapy. Changes in philosophy have resulted in recent improvements in how sexual abuse is prosecuted and treated by the state attorney and public and private agencies. This is important, for many of us have noted that the handling of the incest and sexual abuse episode by authorities may be more important to the final outcome then the actual abuse incident. Dr. Kempe (1977) also documented the emergence of sexual abuse as a major pediatric problem. Physicians who are just now adjusting to the reality of child abuse, must now accept their role of diagnosing, reporting and refering sexual abuse.

Many of us are sick of the physical and emotional damage done to children by abuse. Yet, we are more confused and frustrated by the damage done to the family by the current level of resources available to the families of abused children.

CONCLUSIONS

Child abuse, failure to thrive, neglect and sexual abuse have severe long-term effects on the children of our country. But those children become adults who cannot hold jobs due to physical impairments, adults who can not get jobs due to school failure and drop out caused by "low-level" learning problems. Adults who cannot work due to severe emotional and behavior problems. These behavior problems include angry, acting out, "inadequate" personalities, and inability to effectively deal with others. This is especially devastating if the "other" is his or her child.

The "criminalization" (Bowens, Newberger, 1978) of abuse, treating it is an isolated "illness," results in single-minded, "rescue" attempts that usually fail. Forgotten effects of the "treatment" of abuse are the result of shelter care of foster care. None of us can clearly distinguished how many of the bad effects are due to abuse and how much is due to our community treatment. Should we be so quick to legislate intervention when good help is so rare? Of course we must intervene, and we should intervene—that means help, early. In the case of physical abuse, we know that the abuse incidents tend to escalate in severity. Unacceptable (to the adult) force tends to become acceptable. Physical injury tends to worsen and is more likely to be chronic. Sexual abuse also escalates with age. Failure to thrive worsens, often resulting in death, or destroying the family.

Most "abusive" and "neglectful" parents (the words are disturbing are they not?) love their children. Most of us who care for these people over time will testify to their love. But I must also testify to their lack of skills, their isolation, their anger which they inherit and build on as they discover their inability to deal with their world.

The long term effects documented here are in the context of absence of good care. Our level of understanding limits our treatment of severe, psychotic, or criminal abuse. However, even now we do have the knowledge to successfully treat most cases. With resources and societal pressure we could treat these people. They are people. They are our people.

As I again review the literature concerning abuse, I am reminded that we do know a lot about abuse and neglect. There is far more to know—

Just how many children with cerebral palsy are handicapped due to abuse?

How many adults with mental retardation are retarded due to abuse episodes in their childhood?

Is it true that 100 percent of criminals in court were abused, that 80 percent of juvenile delinquents were abused, that 80 percent of delinquents have learning problems?

What is the total cost of abuse in terms of loss of jobs and loss of human potential?

What is the role of alcohol in child abuse?

What is the role of child abuse in leading to alcohol and other substance abuse?

But what we do not know should not interfere with acting on what we do know. We do known that child abuse cost the United States billions of dollars a year in:

(a) Court costs, law enforcement, jails and detention centers.

(b) Medical treatment, psychiatric treatment.

(c) Social services, social investigation.

(d) Special educational services for: mentally retarded, emotionally handicapped, learning disabled.

We do know that the lack of services can result in severe personal disability, suffering and death—

10 percent of children die if in a home with recurrent physical abuse

30–60 percent are at risk for chronic physical handicapping conditions if left in a home with abuse

30–60 percent have severe mental, emotional or behavioral disturbances that do not seem to disappear in adulthood.

Yet early and adequate treatment can result in a recidivist rate of less than 5 percent. We know that abuse can be prevented by providing human services—medical, social emotional and educational services to those in need, or at risk.

SUGGESTIONS

Educational

Children at all ages should be instructed in school in normal child development and care. Children need to know they have a right to not be abused. Education on child care issues has been shown in Orlando, Florida to reduce teenage pregnancy by 300 percent! This did not serve in anyway as "sex education".

Medical-social

Support systems for isolated mothers need to be put in place prior to delivery, and presented to the family over time, but especially in the first few months. Home visitors should be available for all predictable high-risk groups. These would include isolated teens, mothers of twins, prematures, and any first born child in an isolated family. Also parents who are mentally retarded, mentally ill, or suffering from recent loss would benefit from early support.

Legal changes

The judiciary, law enforcement, and the bar must confront the problem of pediatric or juvenile law. Most laws are for adults, by adults and show no understanding of the special needs of children. We are encouraged by the use of Guardian Ad Litem program in the State of Florida.

Business

Business must identify that stress on the family due to moves, and meetings is a major contribution to abuse. Private pre-school and nurserys at work would alleviate much added stress for the single parent. Business needs to see the possibility of increased potential and increased productivity when families needs are answered.

Military

The high rate of abuse in the military is a major scandal. Isolation of single parent, poor pay, use of "TDY" time and multiple moves all lead to isolation, depression and anger. The huge problem of abuse, neglect and sexual abuse in the military is preventable.

Medical changes

The medical profession needs to use existing knowledge of the obsterical and newborn periods to enhance parenting behaviors and to decrease stress of new parents.

Cultural changes

We need to look at the severe negative effects of our culture's permissiveness of violence, and violence to children. Schools that explore alternatives to corporal punishment should be rewarded. A national policy to teach adults that corporal punishment does not work and contributes to abuse should be initiated using the media.

Legislature

I hope that the legislature will come to see the immensity of the problem of abuse and neglect of our children and parents. Naitonal model law should be drawn up to stop corporal punishment in schools, but providing direction to set up alternatives that allow appropriate control by schools and while developing selfdiscipline in the students. The problem has major impact on the funding needs of law, medicine, eduation and social services. It has a great cumulative impact as adults who were abused enter our society ill prepared to work or to parent.

Child abuse programs need to draw on many levels of experience and training. Current national programs are too limited in scope and too limited in philosophical alternatives and too limited in professional resources.

Legislature must continue to draw from private experience and begin to demand help from business, for the problem can not be handled by government alone.

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STATEMENT OF JANET McALILEY, MEMBER, DADE COUNTY BOARD OF EDUCATION, MIAMI, FLA.

Chairman MILLER. Thank you.

Janet.

Ms. McALILEY. Thank you, Mr. Chairman.

After hearing the testimony of the other panelists today, I feel very privileged to be invited to participate in this hearing.

I am Janet McAliley, member of the Dade County School Board. And I want to welcome you all here to Dade County and to this auditorium. And, in particular, Congressman Bill Lehman, who is a past chairman of our school board.

In response to legislation passed by the Florida Legislature in 1982, a task force on child abuse was formed in HRS district XI, which includes Dade and Monroe Counties. The purpose of the task force is:

One, to analyze the problem in district XI.

Two, to identify and evaluate existing resources for the prevention and treatment of child abuse.

Three, to develop a continuum of services for prevention and treatment.

Four, to prioritize prevention needs and suggest services which should be considered for allocation of funds.

I am submitting for your consideration copies of the district XI plan of action on child abuse. Perhaps there are others present today who are prepared to give additional details of all aspects of the handling of child abuse.

I would like to describe some of the major problems the task force research identified and the steps taken by the Dade County school system, in conjunction with HRS and other agencies, to address those problems.

First is the underreporting of child abuse in Dade County. According to 1980-81 data published by the children, youth, and families program, district XI is ranked first in population at risk and last of the 11 districts in reports per 1,000 children. The statewide referral rate was 28.4; in district XI, it was 15.7. In 1981-82, the State rate was 30.6; district XI was 16.3.

As to neighborhood isolation, on a statewide basis, neighbors were the source of 20.2 percent of child abuse reports while in Dade County, the incidence of reporting by neighbors was only 14.7 percent. One can only speculate that this figure may reflect community language and cultural barriers. Dade County is home to refugees and others who may become residents of transitional neighborhoods.

Children reporting their own abuse: A most troubling fact was that Dade County had one of the highest incidents of children reporting their own abuse, at 3.3 percent compared to 2.6 percent statewide. Reporting from the schools was also slightly lower than the State average.

I remember when I first became a member of the task force visiting schools and speaking with counselors informally and asking them had they much experience with reporting child abuse, the answers varied, but one response that certainly had impact was the statement of a counselor who said she thought other counselors gave children the number so that they could report their own abuse. So naturally we felt we had a lot more work to do with people in the schools.

It was determined that the school system needed to do a better job of training employees to identify and to report child abuse properly. Florida statute 827.07 mandates reporting of child abuse by all school board employees, but in Dade County, with 224,000 students spread out in 251 schools, school-by-school meetings with individual faculties was not feasible.

As an alternative, with the assistance of our superintendent, Dr. Leonard Britton, and the cooperation of Gov. Bob Graham, State attorney Janet Reno, HRS management systems director Phil Maguire and others from the child protection team and victims advocates, school board-owned WLRN taped a 37-minute television program. Governor Graham and Dr. Britton, as well as a principal and a school counselor, stressed the importance of reporting. State attorney Reno explained the law. Mr. Maguire described how reports were handled by his staff. Visual aids illustrated symptoms and examples of abuse. Written materials reiterating all of this information were sent to each school.

Dr. Britton made the program required viewing by all Dade County school personnel on April 1, and at the beginning of school on August 27 of this year.

Since these efforts began, reporting from schools has increased to 12 percent in Dade County, while the statewide average has remained at 5 percent for the period January through June 1983.

Another interesting thing happened. Dade County, as Dr. Cupoli has talked about and others have mentioned today, does use corporal punishment. Florida is a corporal punishment State. But while we were feeding in all this information to school system personnel, which really dealt with physical abuse of children, I think that personnel in the schools became more aware of the sanctity of children's bodies.

And I am very happy to tell you that last year, particularly in the last semester of last year, corporal punishment in Dade County schools dropped to the lowest level it has been since this school system began keeping records on it. We were working on child abuse in other ways too.

The Parent Resource Center, working with a grant from HRS and the Switchboard of Miami, is planning a campaign to publicize a number for children to call if they need help because of abuse or neglect. Mr. A. J. Duhe, a Miami Dolphin, has agreed to film public service announcements, directed to children, advertising the special number to call. The Parent Resource Center and the school system are presently exploring ways to distribute the telephone number to elementary school children.

The idea will probably be something like baseball cards, only it will be something with Mr. Duhe's picture and message, and it will be distributed to children.

Neglect is the most frequent complaint reported in Dade County, and we believe this is an indicator of the need for additional low-cost child care facilities. Some of the persons who testified earlier this morning talked about locking up the schools at 3 p.m. Well, we are really not doing that in Dade County. We have a number of programs after regular school hours in which children and other young people may participate.

Our community schools program, about which I have given Mr. Lehman information which I hope will be distributed to you, deserves comment. We have 53 community schools in Dade County with all sorts of programs, including recreational and help with homework. We have 26 adult vocational programs. You have to be 16 years old to participate in those.

Dade County Public Schools, in cooperation with the YMCA, YWCA, the United Way and others, houses 117 after-school care programs and is making efforts to establish others. There is a fee for this service, $15 a week per child. We don't have enough programs to go around, and this is particularly true in low socioeconomic neighborhoods.

I was visiting one of our Chapter I schools which happens to be located right near this building where we are this morning. I asked the principal if they had an after-school care program. She said 95 percent of the children in her school are on free lunch. She said if their parents can't afford to pay for their lunch, they certainly can't afford to pay for after-school care.

So I would urge you to support the School Facilities Child Care Act, which I understand is still pending in the Congress. This would give us a great deal of help in an area where we need it.

Progress has been made in uniting the efforts of the school system and other agencies to help children who are hurt or neglected. The 1982–83 reporting period, with a total of 7,500 reports, reflects an increase of 1,000 over the prior year.

Recent State revenue shortages have caused the loss of 11 HRS child abuse counselors in district XI, this decrease, coupled with the increase in reporting, is likely to cause delays in responding to children who are in need of assistance.

Another significant aspect of child abuse which must receive greater attention is prevention. Health departments that receive Federal maternal and child health grants could train appropriate workers to identify potentially abusive families. The grants must be expanded to increase the social service staff in order to do this.

These social workers could also provide treatment to identified families.

This is happening to a very limited extent in Dade County now, because there are workers who are going beyond the call of duty to provide these services. But they need to have help in order to expand it appropriately.

Consideration should be given to amending H.R. 1397, the Family Violence Prevention Act, to place greater emphasis than 20 percent of the proposed funding for prevention. Families whose behaviors signal potential violence should be helped before it becomes necessary to flee to shelters.

[Prepared statement of Janet R. McAliley follows:]

PREPARED STATEMENT OF JANET R. MCALILEY, DADE COUNTY PUBLIC SCHOOLS, MIAMI, FLA.

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STATEMENT OF JANE SNECINSKI, DIRECTOR, DAY CARE CENTER, BAPTIST MEMORIAL HOSPITAL OF MIAMI, INC.

Chairman Miller. Thank you.

Jane.

Ms. Snecinski. Good morning. After hearing the other panel members here, I guess I am the bright spot in the morning. I represent Baptist Memorial Hospital of Miami. I believe we were asked to testify because Baptist Hospital has been a forerunner in employer-based and hospital-based child care since the opening of our day care center in April 1964.

With all due respect to child care and day care, we don't take care of days; we take care of children. We were originally opened by the department of nursing as a recruitment tool, not so much to get nurses to return to work after starting families, but to recruit them out to the soon-to-be developed Kendall area.

Anybody from South Florida knows that that was quite some time ago, because Kendall is a booming area right now. We started out with a whopping enrollment of two children at a fee of $0.15 per hour. The program was housed in a free-standing cottage structure already existing on the property and as the demand increased, minor renovations allowed the facility to expand to meet its maximum space allotment, sufficient space for 35 children per shift.

Although the facility maintained the name of the Employees' Day Care Center, it was not until 1970 when the day care center came under the direction of personnel services that the services were actually opened to all employees; the priority, however, remained with full-time and part-time nurses. With a constantly growing waiting list, the effectiveness of day care services as a recruitment tool or an employee benefit decreased due to the lack of ability to meet the needs of a potential employee in a timely manner.

In May 1981 with a waiting list of over 100 children, the board of trustees of Baptist Hospital approved a $750,000 commitment to the employees to build a facility to house children's services, including a development child care program for a maximum of 100 children per shift.

The children's center at Baptist Hospital of Miami opened its doors to children of all employees in May 1983 with the priority given to any child enrolled in a full-time program. We were given the mandate to provide developmental child care, babysitting services, dancing lessons, Saturday recreational program, and on and on.

A zoning variance has been applied for which will increase the acceptable age level to 14 years, enabling after-school care to be offered. We are open from 6 a.m. until midnight, 364 days a year. The present fees range from $48-$53 for full-time enrollment (45 hours) and vary depending on the shift.

While the primary purpose was recruitment, we have found retention to be the primary purpose now; the need is to provide the opportunity for your employees to plan for their child care as they are planning their families. This provides us the ability to not have nursing agencies involved at our hospital. This decreases our cost of nursing for patient care which, in turn, decrease our costs to the patient.

The demand in the Southeastern United States is one that merits special attention. The Southeast population is expected to grow about 19 percent in the 1980's, but it is interesting to note that the population of children under 5 is growing at twice the rate of the American population as a whole. In the Southeastern United States the average number of children in the day care centers or child care centers is expected to grow to 108 children, which will be an average size child care center by 1985.

However, on the other hand, the average weekly rates are the lowest, which reflects the lowest cost of salaries, and the average number of children per staff member is the highest. So you have a very lenient child care staff ratio.

Employees in Southeast United States are special in that very often they are recruited from other parts of the country. This leaves grandma and grandpa up North somewhere when the family moves down, and the family ties there aren't, which cause them to search for child care outside the home.

In addition, people who are recruited to the Southeast area usually are young, still of child-bearing age and still planning families. Additionally, in the Southeast, South Florida, we have a special large Latin community, and we have found the demand for child care from that population is to assimilate the children into the American culture and expose them to the American culture.

With the largest demand in the Southeast and lenient staff ratio, it really becomes imperative to assure the parents that there is going to be quality and affordable child care. Right now there is no requirement for child care workers, almost to the point that if they walk and talk, they can care for children in the community.

For quite a while now there has been a push for regulation certification for child care employees which will assure parents that the staff employed in these centers does know something about child care and about how to provide appropriate activities for the children.

If, in fact, a high standard was established for the certification regulation which could be assured by a testing procedure, and it was a requirement for licensure of a child care center, then it would be up to the employer of the child care center to provide the knowledge to the employees. This would assure that people in the center know what they are doing and can take care of children and relieve the financial burden from anywhere else.

Hospitals have long been a supporter of child care due to the obvious number of women employed in the hospital, usually about 85 percent, and the number of varied needs that the staffing pattern in the hospital requires. A hospital-based child care center has some unique characteristics which can be looked at.

One of them is the extended hours and number of days that a service which is open 24 hours a day, 365 days a year merits. Even though day care centers in a hospital are usually not open 24 hours a day, they do provide coverage for all employees because the people who work the 11 to 7 shift bring their children in the first thing in the morning, and they are allowed a full 8 hours' sleep while children are involved in a quality program.

The hospital staff needs to fluctuate to meet the patient level within the hospital. And if you have outside community child care centers, very often they are open at set times and don't especially care if the parent is going to be held over to take care of patients or if the staff fluctuates to increase or decrease according to patient levels.

Also, we have found in a center within the hospital that the highest standards of infection control, safety and cleanliness that the hospital requires are maintained. This furthermore gives the parents assurance that they are dropping their children off into a surely high-quality program.

A very important aspect in employee-based child care services is that if employers take the responsibility to meet the needs created by their special industry, this won't drain the community of much needed slots within the community.

Just one last thing, in considering a hospital-based child care, as obviously that is my point of view here, there are financial considerations which are coming up and should not be taken lightly. Very often and in the past, the hospital has assumed a financial loss, taking into consideration that child care is an employee benefit. With the future change in Federal reimbursement, the procedures have been creating pressures on the child care centers to become break-even or at least financially stable operations. This is causing an increase in rates and depending on the employees' commitment to the benefit, change in policy and procedures.

There is some anticipation across the country that some centers will be closing. However, there is a hopeful light that most expect to remain open. In employee and hospital-based child care, it becomes an interesting question of actually who is the consumer and who is the program benefiting? Is it the child whose needs are being met, is it the parents who are paying partially or wholly for the service, or is it the employer, in my case, the hospital, whose needs are being met?

This gives an example of the complexity involved in providing child care from an employer's point of view. Thank you.

[Prepared statement of Jane Snecinski follows:]

PREPARED STATEMENT OF JANE SNECINSKI

Baptist Hospital of Miami has been a forerunner of employer-based/hospital-based child care since the opening of its day care center in April, 1964. Originally opened by the Department of Nursing as a recruitment tool (not only to entice nurses to return to work after starting a family but to draw nursing staff out to the yet-to-be developed Kendall area as well) and an employee benefit, the 5 day-a-week program began with an enrollment of 2 children at a fee of $0.15 per hour and covered two shifts. The program was housed in a free-standing cottage structure already existing on the property and as the demand increased, minor renovations allowed the facility to expand to meet its maximum space allotment, sufficient space for 35 children per shift.

Although the facility maintained the name of the Employees' Day Care Center, it was not until 1970 when the day care center came under the direction of Personnel Services that the services were actually opened to all employees; the priority, however, remained with full-time and part-time nurses. With a constantly growing waiting list, the effectiveness of day care services as a recruitment tool or an employee benefit decreased due to the lack of ability to meet the needs of a potential employee in a timely manner.

In May, 1981 with a waiting list of over 100 children, the Board of Trustees of Baptist Hospital approved a $750,000 commitment to the employees to build a facility to house children's services, including a developmental child care program for a maximum of 100 children per shift.

The Children's Center at Baptist Hospital of Miami opened its doors to children of all employees in May, 1983 with the priority given to any child enrolled in a full-time program. The new facility, open from 6:00 a.m.—midnight, 364 days a year, offers a wide scope of services to children between the ages of 6 weeks and 6 years including a developmental child care program, babysitting services, dancing lessons, Saturday recreational program, movies and a summer camp program. A zoning variance has been applied for which will increase the acceptable age level to 14 years, enabling after-school care to be offered. The present fees range from $48—$53 for full-time enrollment (45 hours) and vary depending on the shift.

While the day care center's initial purpose of nurse recruitment has enabled Baptist Hospital of Miami to offer a number of diverse nurse staffing options meeting the hospital's need without the necessity of augmentation by a nursing agency, there has been a shift in primary purpose, exemplified nation-wide, from nurse recruitment to employee retention. This enables employees to plan their return to work in conjunction with their plans for family development. Additionally, Baptist Hospital is striving to meet a shift in demand from babysitting services to diverse child care services (for children of all ages) and an extention of hospital/community services.

The financial and personal needs of career oriented parents, as well as a desire to provide children with a broad spectrum of educational experiences, has significantly increased the demand for affordable, quality child care services. The demand has increased for the infant population and has shifted from babysitting services to quality programs geared to the child's needs. The greatest demand appears to be for infants between 6–8 weeks of age, to enable the mother to speedily return to work after a medical leave, thereby decreasing the financial pressure caused by a lack of an incoming salary. In order for parents to devote their efforts toward the job, or for non-working parents to obtain preschool exposure for their child, there must be assurance that the child care services they have chosen maintain a loving, safe, clean, healthy and stimulating environment for the child. Free from any worry, working parents can concentrate on their duties and responsibilities, resulting in an increase in employee retention rate and decrease in employee turnover rate.

The national needs for child care services vary from section to section of the country and the Southeast region reflects the economic and social facets of its population. The population in the Southeast is expected to increase 19 percent in the 1980's (Harvard Business Review, March–April, 1983) but the population of children under the age of 5 has been increasing at twice the rate of the American population as a whole, since 1980 (American Demographics, September, 1982). Additionally, the employment growth rate for 1979–1990 is expected to equal 26 percent, only surpassed by the Western region (27 percent) (American Demographics, 1982). And proportionally with the enrollment supporting child care centers in the Southeast, the licensed capacity is expected to grow to an average of 108 children/child care center by 1985 (CCIE—Center Directors' Survey, 1983). The average weekly fees are the lowest in the country for all age groups reflecting the lowest average hourly wages in the country for all child care employees (CCIE—Center Directors' Survey, 1983) and the highest number of children per staff member required for licensing ("The Comparative Licensing Study", 1983). Taking the population explosion in the Southeast into consideration, it only seems logical that this region has the greatest number of 3–4 year olds enrolled in child care facilities (National Day Care Study, 1973) and the greatest percentage of centers providing services for younger children (1–2 year olds) (CCIE—Center Directors' Survey, 1983).

The reasons behind the growth in child care services in the Southeast may seem self-explanatory; the growth in child care services increased proportionally with the growth in employment rates. However, the source and type of employees merits consideration. Many employees are recruited from other parts of the country and relocate to the Southeast. This eliminates the familial support system usually offered by grandparents, or other family members and thus creates a demand for outside child care. The majority of the time, the population who has the greatest need, desire and ability to re-locate are young, still of child-bearing age and planning families. Additionally, with the large Latin population who do have strong, available family ties, especially in South Florida, there appears to be a push for child care services to "expose" and "assimilate" the children into the American culture.

With the largest demand, the highest average number of chidren per center, the lowest hourly wage and the most lenient child/staff licensing ratios being in the Southeast, there becomes an imperative need for a quality assurance mechanism to be placed on the child care employees to meet the demand of quality child care. One such mechanism which has been in the creation and implementation process for some time, is a regulated certification which would be required of all child care employees. Hopefully, the mechanism would assure the purchasers of child care that the caregivers have been trained in basic child growth and development, handling skills, cooperative working skills and can carry out appropriate activities. Additionally, there should be an ongoing education requirement to maintain such a certification which would provide caregivers with current knowledge, trends and ideas. This certification could be obtained through a testing procedure which would be based on an established level of knowledge. A high standard will assure quality child care and if this standard is necessary to license a child care facility, the employers of child caregivers will provide the necessary training/education.

Many employers in the Southeast have made a commitment to support child care as an employee benefit. Various degrees of commitment are exemplified by the following efforts: Participation in a referral network, provision of a person within the organization to find appropriate child care services, a contract with an outside source to provide the service off-site and subsidize a portion of the fees, a contract with an outside source to operate and manage child care services on-site while the employer maintains ownership of the building and may or may not provide support services, renovation of space and operation of the service or the building of a facility and operation of the service. Although one may argue that an employer is not in the business of child care, there are many advantages to offering child care services at the place of employment. In this way, good employee relations are fostered and the employer can be assured of a high quality program and the flexibility to meet the demands of the company. Also, it is more convenient for fees to be payroll deducted, tardiness and absenteeism is reduced when the parents have to make only one stop for both themselves and the child, and the parents have a tendency to worry less knowing that should they be needed, the child care facility is within close proximity of their place of work.

Hospitals have long been supporters of child care due to the large percentage of female employees and the number of varied staffing needs to be met. Hospital-based child care presents some unique characteristics which merit some consideration. For example, a hospital-based child care center requires extended hours and services on a 7 day-a-week basis to meet the demand of all employees involved in a 24-hour service business. (Note: the vast majority of hospital-based child care facilities close at midnight but still provide services to the night shift—11:00 p.m.-7:00 a.m.—by providing child care during the day, while the parent sleeps.) Furthermore, in order for the hospital staff to fluctuate to meet the changing patient levels, so too the child care facility must allow enough flexibility to fluctuate in proportion to staffing levels. Also, a hospital-based child care facility is required to uphold the highest standards of cleanliness, safety and infection control standards as are practiced in the hospital. In a community with a shortage of child care services, if the hospital, and other employers, meet these responsibilities, not only are their special needs met, but a drain of child care slots is not created in the community. This allows the outside community's needs as well as the needs of the hospital to be met in the best possible manner.

As hospitals have been forerunners in child-care, they may possibly be the predecessors of the expansion of child care services to family services by industry. As emphasized previously, there has been a thrust for quality child care programs to replace babysitting services. Similarly, there is a push currently to expand child care services to improve different aspects of child's and family's life. Many programs are growing to include dance and arts and crafts lessons, before and after-school care, family outings, information discussions with qualified persons to discuss family/parental concerns and there is a increasing number of parent resource centers, parent support groups and sibling and parenting classes. In the hospital setting, it may be the child care facility that host these types of programs to the community in an effort to create a stonger community/hospital bond.

In considering the operation of hospital-based child care, the operating financial situation should not be taken lightly. In most cases, child caregivers who are employed by the hospital are placed on a salary scale which usually increases retention to such an extent that child caregivers are paid well above the norm due to their longevity in the organization. In upholding the same quality of care which exemplified in the hospital, the staffing ratio in the child care facility generally is much higher than what is required. These additional salary expenses, when added to the other expenses, have resulted in a higher cost of providing child care in the hospital setting. While in the past, most hospitals have absorbed a financial loss in the operation of child care services to provide this employee benefit, a change in federal reimbursement procedures has created pressure of child care services to become "break-even" or fairly self-sufficient operations, depending on the organization's commitment to this benefit. This is causing an increase in rates and change in policies and procedures; the results will become evident within the next few years.

Perhaps then, it is here in the hospital setting that the question of who is the consumer of child care services is best exemplified: Is it the child who receives and benefits from the services, the parent who partially or wholly purchases the services, or is it the employer whose needs are being met? The answer to this question illustrates the growing complexity involved in providing employer-based, quality child care services—the commitment of industry to its employees and its future leaders.

Chairman MILLER. On that point, many employers I have talked to about the issue of child care describe the improvements that they have had in terms of productivity, cooperation of workers, as well as reductions in absenteeism and tardiness.

Do hospitals experience similar benefits?

Ms. SNECINSKI. We have found a significant increase in the rate of retention; the hospital employees schedule their day of return from maternity leave before they leave. When you only have to drop your child off at the same place you park your car to work, you have a very good sense that if something happens, you can be right there. Our absentee and tardiness rate is very much reduced in the hospital, also.

Chairman MILLER. Michael, your testimony touches on the percentage of the adult population in our prisons and jails that were themselves abused as children. What do we know about the population in your State training schools with regard to histories of abuse?

Mr. LEVINE. I don't have specific answers to that. We did a random sample in 1980 of 10 percent of the training school population and found there was reported abuse in over 30 percent of the children. That does not speak to the actual incidence of abuse, but reported abuse was found in that percentage.

Chairman MILLER. The young people that were in the lockup facility responded to an inquiry?

Mr. LEVINE. No, this was in reading their records. That would be reported abuse.

Chairman MILLER. So there is no way to really tell in terms of the actual incidence. Do we know about juvenile populations? Lockup facilities?

Dr. CUPOLI. Yes, there are a number of studies that mention, and never less than 50 percent, saying that children who have been interviewed by the people, who are in this kind of situation——

Chairman MILLER. That is the juvenile population?

Dr. CUPOLI. Yes. One scope of that that I didn't mention was that we don't know the numbers. But we think almost as many children who are physically abused are sexually abused. And one good study of that, 70 to 80 percent of prostitutes had been sexually abused by somebody caring for them, and 70 percent of them said that that was a major reason for them going into prostitution. They had already been used and felt that they may as well benefit from it.

The sexual abuse story is in the written testimony, and it is a great problem. Knowledge concerning sexual abuse in the 1980's is where our knowledge about child abuse was in the 1950's. We are scared to admit to the fact that it is probably at the same level.

Mr. LEVINE. Representative Miller, an additional point I would make is there is a very fine line between corporal punishment and abuse. I think through interviews with children who are in the institutions, to a person, you are talking about children who are beaten at home in a disciplinary manner. I am not sure whether we can determine where that becomes abuse.

Chairman MILLER. Are the State training schools lockup facilities?

Mr. LEVINE. There are lockup facilities within the State training schools. Two of them are fenced in. They are secure to that measure. The boys in the two major training schools live in cottages, so I will not say that they all live in closed cells as is the case in detention.

Chairman MILLER. Where does the facility rate in terms of severity of punishment? In a young person's mind, where would it be on a scale of punishment? Is that the last stop, the State training school?

Mr. LEVINE. In the juvenile system, yes.

Chairman MILLER. You mentioned that only 20 percent of them have been involved in crimes of violence.

Mr. LEVINE. On record, right. That is a good question.

Chairman MILLER. Why are the other 80 percent there?

Mr. LEVINE. Property offenses.

Chairman MILLER. Repeated offenses at this point?

Mr. LEVINE. Yes, repeated offenses. However, as I stated, nearly half, 43 percent, are first commitments, meaning that a lesser type of program, a community program, has not been attempted for that number.

Chairman MILLER. Is the 300,000 hours of community work service, under the JASP program, at the direction of the court?

Mr. LEVINE. The court is not involved in this. It is with the agreement of the State attorney, but it is implemented with private providers in each of the districts in Florida.

Chairman MILLER. This is an effort of diversion by the State attorney's office?

Mr. LEVINE. Absolutely.

Chairman MILLER. So you don't have to take the offender to court?

Mr. LEVINE. No, there is no court involved. If the results are not satisfactory to the State attorney, then there is the option to go ahead and file.

Chairman MILLER. Thank you.

Mrs. Boggs.

Mrs. BOGGS. Thank you. Thank all of you for your testimony, for your work that it represents and for being with us today. Of course, we hear the need for education, and for training. Ms. Bell, who was in the CETA program, one of the fine programs that did allow AFDC mothers to go out and better themselves and help their families to break out of the welfare syndrome; we have cut back on this, which is very difficult.

I am glad to know vocational education is being geared to take care of the needs of the people who need it the most. Perhaps we will find in South Carolina some kind of a system where we can gear vocational education to the job opportunities within the community.

But I was especially touched by the fact that you mentioned the feminization of poverty because throughout the testimony, we are finding it is mostly the children of single-parent families and mostly female single-parent families who are at the greatest risk.

Mrs. LeGard didn't have a chance to say it, but in her written testimony she was very concerned about the job training and educational possibilities of poor children because of computer and other technological gaps. I think this is something we have to address ourselves to, especially if we are going to avoid the feminization of poverty. In an industrial age, of course, we trained women into the lower paying jobs, and they could never break out of the system.

When we have the boys not applying for health service jobs, and young women applying for it and boys applying for the machinist positions, it is mostly because of the pay differential. Boys are supposed to be able to get into jobs that pay more. And the girls get jobs that traditionally have not paid as much.

We are going to have to do something about comparative pay for comparative jobs, whether actually the same job or not, if we are ever going to break the feminization of poverty. So I am very grateful to you for that.

Ms. McAliley, I am especially pleased that you mentioned H.R. 1397, as that is a bill Congressman Miller and I cosponsor, and we will take your advice very seriously.

Mr. Biamby, I was so pleased that you pointed out to us the problem of AIDS and children. As Mr. Miller knows, this has been a very special concern of mine from the beginning of the publicity about the AIDS difficulty. I felt that before it reached crisis proportions, with the effect upon children, that we should try to do something in this committee about it.

You have brought us some very special information today for which we are very grateful. I hope we will call upon the doctors to make certain that the immunologists are able to see that there are specialists out there that can do the research and can do it quickly. If indeed we can infuse some Federal moneys into the program with alacrity and in sufficient amounts, the problem can perhaps be solved in time so that many children would not be affected by it.

I don't think we should wait until it reaches the proportions of polio that so frightened adult parents of my children's generation because it was mysterious, because it attacked so peculiarly, and because they didn't know how to combat it at first. Where we really devoted resources of the country we were able to detect it early enough, to determine what its causes were and develop some type of treatment that controlled and that eliminated the disease. So thank you very, very much for that special concern that you brought us.

Chairman MILLER. Mr. Bliley.

Mr. BLILEY. Thank you, Mr. Chairman.

Ms. Watson, why do you think there is a discrepancy that you have noted between the demand projections for future jobs and the vocational courses that are currently offered in most of the vocational education programs?

Ms. WATSON. Well, I think that vocational education traditionally grew out of trades and industry types approaches to jobs back in the sixties and fifties. And at about the same time that voc-ed was gearing up in South Carolina, we had a tech system that came along which was really the fair-haired child of the State. It was the tech system that got the attention of public relations, publicity, to kind of address itself to high technology and new jobs that were emerging.

I don't really know why people are reluctant at almost every level to talk about voc-ed, except that it does have that perception of being for the academic underachiever, that these are children who after all you know, they don't have the intellectual capacity to succeed; so, therefore, we are going to put them in this program that will keep their hands busy.

I think that that ultimately translates into teaching them the minimum. We still have programs now that are very traditional in nature, and if we decide that we want to spend $50 million a year in State and local money to teach a student how to work on his or her car, or how to build a birdhouse in the backyard, that is fine.

But then we need to call it an avocational system, not a vocational system. The system is not being paid attention to. There is a move in South Carolina, tremendous move on the part of the Governor, to look at public education and to get people to talk about voc-ed within that move. It is very difficult.

Mr. BLILEY. Thank you.

Mr. Levine, you spoke about suspensions. I agree with much of what you say. But what is the alternative? I mean, the alternative when the teacher repeatedly has this problem with this person who is disrupting the class, and the teacher's responsibility to the other students in the class who can't learn because of the disruption? How do we handle that?

Mr. LEVINE. Mr. Bliley, you are painting a very limited picture of the suspension problem. My understanding is that the large majority of suspensions from public schools in Florida are for a category of undefined breach of conduct. When we look at the record, specific records per child, why he was suspended, it is generally in the area of disrespect. Very rarely is it a case of a child being a danger to others.

Now in the area of disrespect, I believe that respect is gotten as it is given. I think that there is a cycle involved with disrespect. I think the child is having problems in school, and that if those are not attended to, that will aggravate the child's behavior. So it is difficult to intercede into the cycle at one point.

But I don't think that children are coming to school with the intent to disrupt. Basically we have a circumstance that our children are being underserved by the school system, and it shows itself in the behavior of disruption. There are very progressive studies out and specific prescriptions of what education systems can do to make their discipline programs much more progressive, and, therefore, decrease the exclusion of children.

I would recommend my colleague's education program to you as one that has generated such research.

Dr. CUPOLI. Mr. Bliley.

Mr. BLILEY. Yes, doctor.

Dr. CUPOLI. Another instance to that is the need for referral for testing. The bulk of children don't have problems with discipline in school in the sense that they are looking for trouble. Many of them have stayed back 1, 2, and 3 years and yet have never been tested for learning problems. I still occasionally see children at 10 years of age who are for the first time diagnosed as mentally retarded. I think that is something that has not been addressed.

The acting out behavior in schools is often due to the school's failure to treat a child's particular needs, often medical needs. The angry fighting child when treated as an individual—there are many model programs across the country that I am sure you have heard about that deal with difficult children. There has been no corporal punishment in a number of schools and many, many less suspensions when the children are treated as individuals rather than as troublemakers.

Mr. BLILEY. I have one question for you, while you are there at the mike. In your opinion, is the incidence of child abuse rising?

Dr. CUPOLI. The reporting of child abuse definitely is rising.

Mr. BLILEY. The reporting.

Dr. CUPOLI. The incidence of child abuse, in the sense of severe cases, I will answer the question directly concerning physical abuse, that seems to be rising.

Mr. BLILEY. What is your opinion for the cause of that rise?

Dr. CUPOLI. Anybody who has written about child abuse tends to talk about four major causes: chronic stress, precipitated by failure to deal with a very specific stress; isolation; community standards that support violence. Financial burden is the most common recurrent stress.

Child abuse also occurs in middle and upper classes. It is more likely to be emotional abuse and neglect. If I were to adopt a child who had been abused, I would probably adopt a physically abused child because that is episodic, whereas neglect and emotional abuse tends to be chronic and much more devastating over time.

We don't know how to take care of our kids. There are very few mothers 20 to 25 in this generation who have ever babysat or taken care of a younger brother or sister. And to take home a 2-day-old child that is kicked out of the hospital without any training because there are people coming in behind, and going home to an empty home, is an incredible disadvantage and disservice.

The story that I tell is that of a 19-year-old girl mother who has had a child, now in the second month of age. He has had diarrhea, has an earache and grandmother just went home. The child, maybe he is 2½ months, now he turns over and gets some diarrhea on the bedspread. The mother grabs him by the ankle and pulls him back onto the bed. If she is lucky, she will hurt the child's knee just a little bit. If she is not so lucky, she will hurt the child more. The child will cry for a day. He will go to the hospital. Diagnosis of abuse will be made at a low level, just a little chip on the knee, and she will get supportive service and break into her frustration before it gets worse.

If she is very unlucky, she will miss the bed, the child will break his leg and be taken away from her, never to be returned; the State average for foster care is 3.3 years. If she is really unfortunate, the child will hit his head, it will be fractured, and she will go to jail. I think if we taught child development, not just child education, but role models, 6-year-olds taking care of infants in the school, that would make an impact.

Mr. BLILEY. Thank you.

Ms. Snecinski, having served on three hospital boards, I would like to know, how did you prevail upon the board to come up with $750,000, and how did they get it? Did they pay it out——

Chairman MILLER. You can plead the fifth, if you like.

Ms. SNECINSKI. We had a waiting list of well over 100 people at the time. The children's center was no longer of benefit, it was no longer a retention tool, it was an aggravation for the employee. We made that commitment to the employees, and we don't have a waiting list anymore. As a result, we have brought in people from all over the country through recruitment.

Mr. BLILEY. How did they raise the money, the $750,000, to build the new facility? Was this included in their overhead for which they are reimbursed, or did they have a public, a campaign to raise $750,000?

Ms. SNECINSKI. Both. It was one phase of the expansion process at the hospital.

Mr. BLILEY. Is it a reimbursable expense, in other words?

Ms. SNECINSKI. No.

Mr. BLILEY. It is not?

Ms. SNECINSKI. No.

Mr. BLILEY. So it either had to come out of accumulated surplus, or from operational?

Ms. SNECINSKI. Operational.

Mr. BLILEY. Your $48 to $53 a week charge, how does that compare with the going rate for child care facilities in the community outside?

Ms. SNECINSKI. In our area, South Miami, we are at the lower end of the middle range. In relation to other hospitals around, we are right in the middle. Many child care centers around the area are up to $60, $70 a week.

Mr. BLILEY. What percentage of the total cost of operating the facility does your fee represent? In other words, how much is the hospital picking up?

Ms. SNECINSKI. The hospital is picking up approximately $150,000 a year.

Mr. BLILEY. How does that translate?

Ms. SNECINSKI. We are recouping about 80 percent of our salary expense.

Mr. BLILEY. In other words, 40 percent is being subsidized or taken care of by the employer and 60 percent by the employee?

Ms. SNECINSKI. Twenty percent of the salary expense. All the overhead, all the food, all the supplies are subsidized by the hospital.

Mr. BLILEY. So the total would probably be close to—close to 70-30?

Ms. SNECINSKI. It is close to 50-50 total expense.

Mr. BLILEY. Well, if 60 percent of the cost is furnished by the employee——

Ms. SNECINSKI. Sixty percent of the salary expense.

Mr. BLILEY. But the other overhead is not counted, that would go into the employer's contribution too.

Ms. SNECINSKI. Right.

Mr. BLILEY. My chairman is getting fidgety over here. I will address that at another time.

I apologize, but I think it is a marvelous program and one to be commended not only to hospital employers but all employers that can.

Mrs. BOGGS. Baptist Hospital in New Orleans has not as extensive a program, but a similar program, a very enlightened plan.

Chairman MILLER. Congressman Lehman.

Mr. LEHMAN. I just would like to address one item, then maybe a second quickly.

How many of you have read this week's Newsweek, "To Kill or Not to Kill," the young man whose execution was stayed after he was strapped down in Texas for the lethal injection? That was a perfect case of the result of child abuse, if anybody read that. They even had photographs in that story of this 10-year-old child with the hard eyes.

So what I am thinking about is beyond even the salvaging of the family or salvaging of the child, himself and his future. These abused children are nothing but walking time bombs ready to destroy whatever gets in their way. This man was saying, "Things just happen. Things just happen." He blew away three innocent people in buying a six-pack of beer. That is what happens as a result of child abuse.

I want to congratulate you on your statement on corporal punishment. I would like to comment from my own experience, we should try to isolate those students that seem to be the victims of corporal punishment. I was on the school board, I was a teacher in two high schools. Ten percent of the teachers, 2 percent of the teachers were 95 percent of the corporal punishment. It is certain teachers that originate it, this type of so-called corrective behavior, and it becomes not a punishment.

When I was at high school, the young student had a choice of either detention or whacks. So what does any red-blooded 15-year-old boy choose? If he takes detention, he is a sissy. And the person that provides this punishment, and you can say what you want, but in corporal punishment between an adult and a young man, there is sadist-masochist sexuality. And it exists. Nobody brings that up. And it is true.

Also we have to think about in corporal punishment, is it a reflection on our violent society? What is the position of the Dade County Board of Education?

Ms. McAliley. They have a position on record which they presented to the board in 1976. I have a copy of it. They are opposed to any restrictions beyond what is in State law.

Mr. Chairman, one way we have been able to reduce the incidence of corporal punishment in Dade County is to keep the records of it differently than we have before. And I think we can now more easily identify who is doing it and who is receiving it, and so forth.

There has been some opposition to the—even changing the way we keep the records on it. The teachers' union is one of the groups that has objected to that. But we are——

Mr. Lehman. Next time you negotiate with the teachers' union, let's make that part of the negotiation process.

Ms. McAliley. That is a good idea.

Mr. Lehman. I did the same thing when I was on the school board. I will tell you something very strange. A 16-year-old child can drop out of the school system if he is a corporal punishment victim and go into the adult education system, and he is not a corporal punishment victim, he is not a problem. There is a change. He is treated as an adult. All of a sudden he doesn't need whacks anymore. So it isn't the child necessarily.

The other thing is, he got whacks from the fourth grade. He goes to the community college, 13th grade. He doesn't get whacks anymore. What happens between 12th and 13th? It isn't the child that has changed. It is the system. If you are going to whack boys, why don't you whack girls? Or do you?

Ms. McAliley. We do whack girls too.

Mr. Lehman. I mentioned sadomasochism once. I don't think I need to mention it again. Who whacks girls?

Ms. McAliley. The assistant principals or principals who administer the discipline. It may be a male administering it to the female.

Mr. Lehman. You have got a problem.

Ms. McAliley. I think so too.

Mr. Lehman. Then I want to mention one other thing about vocational education. I fought that thing in Congress and fought it here about putting them in front of a $50,000, $75,000 machine and telling them to learn something about high technology. These are the ones that aren't ready for that kind of equipment.

So they put junk machines in vocational education and then try to teach them voc-ed, is that right?

Ms. **Watson**. I don't know if I would call them junk machines. I am just not sure what we are teaching them in voc-ed is relevant to the kinds of jobs they can get.

Mr. **Lehman**. I went over to two countries. They don't take the ones that can't go to college, they don't take the ones that are losers academically. They take the best of the students. That was Switzerland and Israel. Man, if you aren't smart, you don't get vocational education in those two countries.

The same thing happens in Japan, and I would like to see what their voc-ed looks like over there. That is why we are slipping behind in our high-tech society, and we better get our vocational education program straightened out and not make it a stigma. It was a stigma to go into voc-ed. It is still a stigma. It is almost like "being a retard," you know that phrase.

Ms. **Watson**. A real pity about it too is that there are some voc-ed systems that are now teaching computer technology. And where computer technology is put under the program heading of business and office occupations, which it is predominantly female enrollment, but if you look at computer courses, it is usually white males in the computer programs.

So all you have to do is have a program that relates to high-tech that people think is going to find people a job and suddenly the students who are in voc-ed all these years don't get in those programs.

Mr. **Lehman**. You are coming at it from a different angle. But I would like—if we wanted to do a junket, we could go study voc-ed in Switzerland.

Chairman **Miller**. Thank you.

I want to thank this panel. I think this has been a tough panel, but I think a very important one for this committee and for the people who are participating in our efforts. I think that you have pointed out the incredible problem we have with continuing to fund so many of the failures, and the cost that that brings to us.

But also you have been able to highlight for us, maybe most dramatically through Ms. Bell, the opportunities for success if we reach for it. It can happen across the board.

I just want to thank you very much for your time and your testimony. One of these nagging problems I have in my seat on the Education Committee is how we are going to get job training to mesh with job opportunity. It will not be easy, but I believe we are going to get there.

Thank you very much for your time.

The committee will recess until 1:30, and it is our intent to come back and hear the third panel.

[Whereupon, at 1:00 p.m., the committee was recessed to reconvene at 1:30 p.m. the same day.]

AFTERNOON SESSION

Chairman Miller. The select committee will come to order.

At this time we will hear from the third panel. It will consist of Linda Irwin, executive director of Youth Alternatives, Inc., New Orleans, La.; Ellen Hoffenberg, program director of Guardian Ad Litem, Tallahassee, Fla.; Mario Jardon, who is executive director of Northwest Dade Community Mental Health Center; Ana Rivas-Vazquez, clinical director of the Children's Psychiatric Center, Miami; Marie Mitchell, coordinator, teen services program, Grady Memorial Hospital, Atlanta, Ga.; and Maurie Pressman, medical director, Horizon Hospital, Clearwater, Fla.

Please proceed.

STATEMENT OF LINDA IRWIN, EXECUTIVE DIRECTOR, YOUTH ALTERNATIVES, INC.

Ms. Irwin. Mr. Chairman, and members of the select committee, I am Linda Irwin, executive director of Youth Alternatives, Inc. in New Orleans. Founded in 1853, we are a private nonprofit agency with 130 years of continuing service to children and youth in need.

One of our current programs, the Greenhouse, has for 11 years been the only emergency shelter and crisis counseling center for runaway and homeless youth in New Orleans. It is from this perspective that I am pleased to address issues of interest to this committee regarding crisis intervention needs of youth and the challenges related to trying to meet those needs.

One of the first difficulties we face in addressing these issues is identifying the number of families and youth in crisis. When figures are projected for the number of runaway youth in this country each year, the upper and lower limits of the range may differ by hundreds of thousands. An assumption in those projections is that the majority of runaways may never be reported as missing by their parents.

In the most recent data available in New Orleans, the mayor's task force on human services estimated in its comprehensive needs assessment of March 1980 that 5,000 to 8,000 runaways pass through New Orleans annually. This report further indicated that neary 50 percent of these youth are pushout or throwaway youth from families who cannot care for them or do not want them.

Since running away in Louisiana is a status offense, police statistics give some hint of the number of youth in need. One hundred ninety-five juveniles up to 16 years of age were arrested for 217 incidents of runaway behavior by the juvenile division of the New Orleans Police Department according to their 1982 annual report.

Lieutenant Max Gagnard of NOPD indicates, however, that due to cutbacks in the juvenile division and the high incidence of more serious crimes involving juveniles, runaway offenses were often not given much attention or youth were directed to the Greenhouse. In suburban Jefferson Parish, reports indicate 1,240 arrests of runaway youth by the juvenile division of the Jefferson Parish sheriff's office in 1982.

Many homeless youth are away from their families because they have been the victims of abuse and neglect. In 1981 the child abuse unit of the New Orleans Police Department reported handling 1,032 cases involving children to age 16 where physical or sexual abuse or neglect were suspected.

Suzanne Danilson, program specialist of the Orleans Parish Crisis Intervention Unit of Children's Protective Services, recently reported that the child abuse hotline is averaging 300 calls per month in the first half of 1983. She further projects that perhaps no more than one case in four is reported.

In Jefferson Parish in 1982, the sheriff's office reported officers intervening in 3,119 crises involving youth and their families. These crises often include physical and sexual abuse and/or neglect.

Given all these statistics, it is still difficult to determine an accurate projection of the number of runaway and homeless youth in New Orleans who need emergency shelter and crisis intervention services. What we do know is that the fiscal year just ended reflected a 12-percent increase in the utilization of our shelter over the prior year.

Furthermore, for the 6-month period ending September 30, our average occupancy rate was 86 percent. In a facility with a dynamic bed capacity such as a shelter where the population may change daily, this is a very high percentage. I think an amazing statistic is that in a 5-year period the number of residents living in single-parent households headed by their mothers increased from 18 percent to 40 percent.

Fewer youth are returning home after leaving our program, and perhaps most significantly between 1965 and 1981, the number of residents reporting abuse at intake doubled. This partly explains why fewer youth have returned home after leaving us. For the last half of the last fiscal year, 73 percent of the residents in our program were either already in the State's custody or it was determined that the youth was in danger of being abused if returned home.

Length of stay has also shown a sharp rise, since youth awaiting alternative placement require temporary shelter during the placement process. The Greenhouse, like other shelters, provides temporary shelter, individual, group and family counseling for residents and nonresident youth and families, information and referral, client and family advocacy and systemmatic outreach.

It is very difficult to communicate the trauma behind all of the data and statistics regarding the number of runaway youth. For example, last year I had the experience of being on duty at the Greenhouse when one of our female residents tried to commit suicide by cutting her wrist. Her comment to a counselor while we were waiting for an ambulance was "I didn't really want to hurt myself, but I wanted someone to understand that I don't want to go back to the housing project to live, and I don't want my grandfather to rape me anymore."

Every one of the statistics has a story behind it like that young woman's. The greatest chance of successful intervention in family crisis involving runaway youth occurs when recognition occurs that it is the family system which is in crisis, not just the young person. Chances of success are greater when the family wants the youth back in the family and when the family has the economic and emotional resources to solve their problems and resolve the crisis.

The biggest challenges we face are with youth the family does not want and with those youth that come to us from abused and neglectful situations. With abused and neglected youth, the system designed to respond to them often continues victimization of them. Sometimes this is a result of the fact that the youth have not received information as to the process in which they are involved and what is going to happen to them. Often it is because the system is so overloaded it has become unworkable.

Furthermore, and perhaps more dangerous, is the system's ambivalence about when to intervene. What I call the "not-bad-enough syndrome." Partly as a result of the legal restraints under which the system operates and partly because of a real desire to resolve family crisis in the home if possible, the end result of this drift in intervention is that the message the youth internalizes is, "I have to get hurt worse than this if I am going to be helped."

The attitude is reflected in the current Louisiana Office of Human Development Policy which reimburses us in our program only for care of youth who are in the State's custody or if it is determined that they are in imminent danger of abuse if they return home. We can no longer receive assistance from the State for a "voluntary" youth who comes to us from a family in crisis where if the crisis is temporarily resolved the State may not have to intervene further on a long-term basis if the youth successfully returns home.

If it were not for the Federal Youth Development Bureau moneys our program currently receives, we would not be able to serve these youth in a preventive capacity at all, and these youth are currently 27 percent of our population.

Possible responses to crisis intervention needs are many. Certainly community-based groups need to continue to explore ways of providing services such as parent education groups, parents' anonymous groups, hotlines, et cetera. The youth themselves need access to information about services they can access on their own.

I think the role of the schools here is very, very important. Peer support groups for youth and at-risk families are very important. Private industry can encourage these same services.

Training is an important issue: Training of workers in crisis intervention services, whether public or private, need to be designed to train multiskilled professionals who can provide emotional support to traumatized youth, intervene therapeutically in emotional crises and negotiate service delivery systems. Crisis intervention services must be available to abused children and youth, not only because of the immediate trauma, this was emphasized so much on the second panel, but because those abused youth are likely themselves, if the trauma is unresolved, to become abusive parents.

There are also some issues which I do not address, but which I think are pertinent for consideration of the committee in the whole area of spouse abuse as well. Other at-risk populations include pregnant teenagers, the poor, and the unemployed. Statistics on these populations in New Orleans are staggering. Studies indicate that in 1979 one out of every eight female teenagers in New Orleans was pregnant. Data lists New Orleans as the third poorest city in the Nation with 34 percent living below the poverty level. Forty-four percent of the families in New Orleans with children under the age of 17 are below the poverty level; 44 percent of families with children.

The unemployment rate in July in Louisiana was still at 10.8 percent. It is partly because of these larger issues that the Federal initiative in crisis intervention services must remain strong. The very situations which create a need for our services also mitigate against the likelihood that local and State revenues will be available to support them or that the private sector can move in its support.

The tax base in New Orleans, because of our high poverty and unemployment rates, is too low to support needed services. Louisiana, as Congresswoman Boggs well knows, is an oil and gas State whose revenue base plummeted with world crude prices. Because we are so dependent on oil and gas industries, our economy is lagging behind the rest of the Nation in recovery.

Because our recovery is lagging behind the Nation's recovery, our ability to access funds through the private sector then is also limited.

The Federal initiative can be important in mandating a nationwide attempt to identify families and youth in crisis. Accurate data collection and projection of at-risk populations will be necessary to assess needed new services and how they should be designed, implemented, and funded.

Once identified and when service delivery capacities are in place, there needs to be continuing demand for program evaluation and followup services delivered. We simply have to know if what we are doing is effective.

For my community, perhaps the most important contribution this committee can make in addressing the need for Federal policies that address issues which significantly impact the health and well-being of the American family, is to link the intent of Congress in that regard as strongly to the work of the Labor and Commerce Departments as to the Departments of Health and Human Services, Housing and Urban Development, and Justice. Any national economic recovery which still leaves untouched what we have now come to call the hard-core, urban poor and unemployed will leave my community with as many families in crisis as ever.

Particularly on behalf of the youth in our programs, but also on behalf of our board of directors and staff, I want to thank you for the opportunity to submit this testimony. I would like to invite you to visit Youth Alternatives, Inc. I would like to leave you with the words of a 17-year-old former Greenhouse resident who lived on the streets for about 3 years. She said to a counselor, "I added 10 years to my life on the streets. You wonder how people can think you are young. I can't ever be the same again. * * *"

[Prepared statement of Linda Irwin follows:]

PREPARED STATEMENT OF LINDA IRWIN, EXECUTIVE DIRECTOR, YOUTH ALTERNATIVES, INC.

Chairman Miller and members of the Select Committee, I am Linda Irwin, Executive Director of Youth Alternatives, Inc. in New Orleans. Founded in 1853, we are a private, nonprofit agency with 130 years of continuing service to children and youth in need. One of our current programs, The Greenhouse, has for eleven years been the only emergency shelter and crisis counseling center for runaway and homeless youth in New Orleans. It is from this perspective that I am pleased to address issues of interest to this committee regarding crisis intervention needs of youth and the challenges related to trying to meet those needs.

SCOPE OF THE PROBLEM

One of the first difficulties we face in addressing these issues is identifying the number of families and youth in crisis. When figures are projected for the number of runaway youth in this country each year, the upper and lower limits of the range may differ by hundreds of thousands. An assumption in those projections is that the majority of runaways may never be reported as missing by their parents.

In the most recent data available in New Orleans, the Mayor's Task Force on Human Services estimated in its Comprehensive Needs Assessment of March of 1980 that five to eight thousand runaways pass through New Orleans annually. This report further indicated that nearly 50 percent of these youth are "pushout" or "throwaway" youth from families who cannot care for them or do not want them.

Since running away in Louisiana is a status offense, police statistics give some hint of the number of youth in need. One hundred ninety-five juveniles up to 16 years of age were arrested for 217 incidents of runaway behavior by the juvenile division of the New Orleans Police Department according to their 1982 Annual Report. Lt. Max Gagnard of N.O.P.D. indicates, however, that due to cutbacks in the juvenile division and the high incidence of more serious crimes involving juveniles, runaway offenses were often not given much attention or youth were directed to The Greenhouse. In suburban Jefferson Parish, reports indicate 1,240 arrests of runaway youth by the juvenile division of the Jefferson Parish Sheriff's Office in 1982.

Many homeless youth are away from their families because they have been the victims of abuse and neglect. In 1981 the Child Abuse Unit of the New Orleans Police Department reported handling 1,032 cases involving children to age sixteen where physical or sexual abuse or neglect were suspected. Suzanne Danilson, program specialist of the Orleans Parish Crisis Intervention Unit of Children's Protective Services, recently reported that the child abuse hotline is averaging 300 calls per month in the first half of 1983. She further projects that perhaps no more than one case in four is reported. In Jefferson Parish in 1982, the Sheriff's Office reported officers intervening in 3,119 crises involving youth and their families. These crises often included physical and sexual abuse and/or neglect.

Given all these statistics, it is still difficult to determine an accurate projection of the number of runaway and homeless youth in New Orleans who need emergency shelter and crisis intervention services. What we do know is that the fiscal year just ended reflected a 12 percent increase in the utilization of our shelter over the prior year. Furthermore, for the six month period ending September 30, our average occupancy rate was 86 percent. In a facility with a dynamic bed capacity such as a shelter, where the population may change daily, this is a very high percentage.

CHANGES IN CLIENT POPULATION

Not only are we seeing an increase in the numbers of youth seeking shelter, but the "profile" of the youth in crisis is changing. In May of 1982, René J. Toups, a graduate student at the University of New Orleans, completed a study of intake data using a representative sample of Greenhouse residents in 1975, 1978, and 1981. His findings indicate some significant changes:

(1) There has been an increase in the percentage of minority youth seeking services;

(2) There has been a steady increase in the number of residents from the New Orleans area;

(3) There has been a significant decrease in the number of youth who were living with both parents prior to coming to us for shelter and a dramatic increase in the number of residents who were living with their mother only. In 1975, 31 percent of the youth sampled lived with both parents; in 1981 this figure had dropped to 17 percent. In 1975, 18 percent were living in a single-parent family with their mother; in 1981 this figure had risen to 40 percent.

(4) There has been a decline in the number of youth returning home upon leaving The Greenhouse. There was a decrease of 12 percent in this area between 1975 and 1981, from 46 percent to 34 percent.

(5) The most significant change may be that between 1975 and 1981 the incidence of reported abuse by residents at intake doubled. The tremendous rise in the incidence of reported abuse by residents partly explains the decrease in the number of youth returning home after leaving The Greenhouse. For the last half of fiscal year 1982–83, 73 percent of the youth who were residents in The Greenhouse were either already in the custody of the Louisiana Department of Health and Human Re-

sources, or they were from families where it was determined that the youth was in danger of being abused if he or she returned home.

This may also explain why the average length of stay of residents has shown a sharp rise. Youth who are awaiting an alternative placement because they cannot return to their families will require temporary shelter for a longer period of time. In the last five months the average length of stay has been 11.1 days, compared to 6.2 in 1975, and 4.9 in 1981.

SERVICES PROVIDED

Like other shelters operating under the standard model regulations developed by the Youth Development Bureau through the Runaway and Homeless Youth Act, The Greenhouse is a community-based, voluntary program whose services are accessible to youth 24 hours each day. Services currently provided include:

(1) temporary shelter for sixteen youth;

(2) individual, group, and family counseling for both residents and non-resident youth and their families;

(3) 24 hour crisis phone counseling;

(4) information and referral services, as well as advocacy with and for youth and their families to access needed services for crisis resolution; and

(5) systematic community outreach efforts.

At the end of a decade of providing these services to youth, The Greenhouse conducted a direct mail needs assessment among 469 New Orleans professionals to determine priority needs in the area of crisis intervention services for youth. These professionals included residential treatment staff, mental health center workers, community social service representatives, school principals, school guidance counselors, and social workers, child protection workers, probation officers, juvenile police officers, juvenile judges, and youth advocacy legal services. Approximately 40 percent of those surveyed responded.

When asked to rank thirteen services adolescents in crisis might need in a 1-13 priority ranking, the three highest priorities were (1) individual counseling, (2) temporary shelter, and (3) family therapy/counseling. When asked to rate each of the thirteen services on a 1-7 scale of their relative importance to troubled youth, the service rated most important was youth employment programs. It was confirmed for us, then, that the professional community sees our services as addressing priority needs of troubled youth. Our shared concerns with other professionals regarding youth employment opportunities will be addressed further in a later section.

All of the data we collect regarding numbers of youth and families in crisis, who they are by numerous demographic descriptions, tells only part of the story. I am an administrator. That means that in an agency like ours, my role dictates that the vast majority of my interactions are with colleagues I supervise within our programs, representatives of funding sources, members of the Board of Directors, community professionals, and occasionally an esteemed body such as this. It is easier than I care to admit to become isolated from direct contact with the residents in our programs who are the pulse of these data. This was made frighteningly apparent to me about a year ago when I happened to be covering The Greenhouse one Sunday afternoon.

One of the female residents was scheduled to return home that evening. Just before dinner another resident came to me and suggested that I go upstairs to check on "Shirley." He was afraid she was going to hurt herself. When I got to the girls' dorm, "Shirley" was lying on a couch, there were thin streams of blood at her wrists, and she clutched a razor blade in one hand.

I sat down next to her and asked her to give me the razor blade so we could talk about what was happening. She didn't respond to my questions, but began to move toward cutting her wrist again. I grabbed both her arms, sat down on her legs to hold her still, and began to yell for help. However, no one could hear me and I was afraid to leave her alone to summon someone. Fortunately, I knew that a counselor would be walking past our door in a matter of minutes to come on duty. Since "Shirley" began to struggle every time I asked her anything about what she was doing or why, I decided that the safest things to do was to wait until I heard the counselor and call for assistance. It is the height of the obvious to say that there is no appropriate way in such a situation to "make conversation." It is said that when one is in danger, one's entire life passes before one's eyes in a few seconds. In those few minutes of attaching myself to someone else's peril, what flashed before my eyes for review and confirmation were all the values I hold about the sanctity of human life.

The counselor came as expected and together we were able to safely retrieve the razor blade. While I was calling an ambulance, "Shirley" told a counselor, "I didn't really want to hurt myself. But I wanted someone to understand that I don't want to go back to Desire (Housing Project) to live, and I don't want my grandfather to rape me anymore."

It is difficult to convey the power of those words in the data I have provided. And it is youth like "Shirley" whose stories weave the fabric of the larger story we are trying to tell. Knowing that it is youth like her who make up the percentages quoted, I would like to address some of the challenges of trying to help.

CHALLENGES

On of the most prevalent misconception about runaway and homeless youth is the assumption that the runaway is "sick" or "bad," and one of the biggest challenges counselors in our program face is reshaping that thinking to see that a runaway represents a family system that is in crisis. Sometimes the runaway is the healthiest person in that system because his or her behavior precipitates an end to denial of the crisis.

In talking with Greenhouse counselor Claudia Dabbs this week, she indicated that counselors realize that they will experience their greatest chance of successful intervention with a family which accepts this reality, which wants their children back, and which has the emotional and economic resources to resolve conflict. In this case counselors' therapeutic skills can be applied and crisis can be resolved in workable ways. They frustration counselors face is that the number of youth they are seeing from families like this is declining.

Perhaps the biggest challenge we face is in addressing the needs of those youth in need of shelter because they have been victims of sexual, physical, and/or emotional abuse or neglect. Because of recent media attention to these problems, the public is thankfully becoming more aware of the danger of victims of abuse who run away, becoming further victimized on the streets. But it is one of the greatest challenges we face as human service professionals to redirect our ways of intervening with youth who have been abused so that we do not also further contribute to their victimization.

Greenhouse counselors find that youth alleging abuse and neglect usually have little or no understanding of the process in which they are involved and rarely is it explanied to them by the workers who are investigating their allegations. Realizing this, Greenhouse counselors recently asked a local child protection worker, a good worker, to come to afternoon group at the Greenhouse to explain how a youth reports abuse and how the report is handled from there. The worker refused the invitation. She said that in all good conscience she would have to recommend to the youth that they not report the abuse unless they were in terrible danger because the system designed to respond to them is so unworkable.

I want to hasten to add that I am not attempting to impugn the skills or motives of most workers in the system. It is simply a system that, because of its own overload and because of the ambivalence of the larger society regarding interfering in "family matters," is constrained from acting in the best interest of the youth.

We have all experienced the tension between our commitment to work to reunify a youth with his or her family and the hard reality that we sometimes need to recommend that that bond be broken by state intervention. With abused youth that tension often leads to an insidious drift in intervention that can only be described as the "it's not bad enough yet" approach. This can best be exemplified by the times counselors have heard workers say in looking at youth's bruises or scars," "There simply is not enough evidence here." While we can certainly understand the legal constraints under which the system operates, the message to the youth is quite clear. "We can't help you until you get hurt worse than this."

A current policy of the Louisiana Department of Health and Human Resources Office of Human Development is reflective of the "It's not bad enough yet" approach. Prior to August of 1982, the policy of the Department had allowed our program to receive state reimbursement for the cost of services to all youth who were sheltered at The Greenhouse. The idea was, of course, that if a youth came to the program and a successful intervention was made in a family crisis, then it was less likely that family stress and conflict would build to the point that abuse might occur. The reimbursement by the Office was seen as part of its role in funding preventive services.

However, as part of its response to cut expenditures in the face of declining state revenues, the Office will no longer reimburse us for costs of services to these "voluntary" youth. They will reimburse us for clients in the custody of the state or where the risk of abuse is high . . . that is, "when it gets bad enough." Currently, without Youth Development Bureau funds to The Greenhouse, we could not provide services to 27 percent of our residents from families in crisis who do not meet the funding criteria of the Office of Human Development.

WHAT, THEN, SHALL WE DO

Some of the ways to address crisis needs in a preventive fashion are deceptively apparent. For example, no one would deny that community-based services such as community centers, churches, YMCA/YWCA's, etc. have a significant contribution to make in providing parent education classes, sponsoring Parents Anonymous groups for abusive parents, staffing emergency hotlines and warm lines for crisis counseling or parenting information, and sponsoring peer support groups for youth in at-risk families. Certainly, school curriculums need to include parent education classes for youth, and school personnel need to make youth aware of services available to them in their community which they can access on their own. In private industry, employer assistance programs can provide the same services or can provide information and referral services to employees.

Training of professionals who work with youth in crisis intervention services is another key area that can be addressed. Workers in Children's Protective Services need not only to be trained as good case managers and investigators, but they need to be skilled in providing the emotional underpinnings a youth needs while in that system. They particularly need to be expert in understanding the dynamics of separation and grief since so many youth with whom they are working are experiencing the dissolution of family bonds. Workers in services such as ours, however, need to be trained well as counselors and equally well trained in the ability to negotiate service delivery systems since so many of the youth and families with whom we work need systems advocacy. There are implications here for social work and psychology curricula at both the undergraduate and graduate levels. There are also pertinent issues of concern to Congress. The Runaway and Homeless Youth Act authorized money for training of professionals working in programs funded under the auspices of the Act. However, it appears now that money for training is being either cut or redirected by administrative decision within the Department of Health and Human Services.

Perhaps the most important way to prevent the kind of family crises which produce children and youth in crisis is to identify at-risk populations and to develop early intervention strategies for those groups. There is no doubt that the population most at risk of becoming abusive parents are those parents who were abused themselves as children. This is one reason why the abused child must have crisis intervention services delivered by professionals committed to providing the emotional support necessary to help the youth cope effectively with the trauma he or she is experiencing and to help the youth integrate a positive self-concept. Many abused children and youth blame themselves for what has happend to them and believe that they are "bad," "unworthy," or "unlovable." If those concepts are internalized, the youth is likely to develop a self-destructive lifestyle, and the seeds are also sown for the next generation of abusive parents.

Other at-risk populations include pregnant teenagers, the poor, and the unemployed. It is imperative that we not suggest that any individual in any of these groups, or the groups as such, are bad parents. But their lack of resources can certainly produce stresses which create or exacerbate family crisis. In New Orleans, a review of demographic data is a staggering experience.

In 1979, Dr. Flora Cherry of the Maternal Child Health Section of the Tulane University School of Public Health researched the adolescent preganancy rate in New Orleans. Her study indicated that in that year one of eight teenage girls in New Orleans was pregnant. In 1982, 31 percent of the babies delivered at Charity Hospital in New Orleans were born to mothers under the age of 20. 46 percent of all births to women of all ages at Charity in 1982 were born to women who were not married. This means that the emotional stress of parenting is increased for these women by being single-parent with very limited financial resources.

The 1980 census data indicates that New Orleans has the third largest percentage of people living beneath the poverty level among large cities in the nation. 26.4 percent of the population of New Orleans lives below the poverty level. 44 percent of the families with children under seventeen are poor. In July of 1983 our unemployment rate was 10.8 percent. Figures released this past week indicate that the unemployment rate is improving except for certain populations. For example, the unemployment rate among the nation's black male youth is 52 percent. In a city like New

Orleans whose population is over 50 percent black, I can only assume that the youth unemployment rate remains of crisis proportion.

It is partly because of these larger issues that the federal initiative in crisis intervention services must remain strong. The very situations which create a need for our services also mitigate against the likelihood that local and state revenues will be available to support them or that the private sector can move in its support. The tax base in New Orleans, because of our high poverty and unemployment rates, is too low to support needed services. Louisiana is an oil and gas state whose revenue base plummeted with world crude prices. Because we are so dependent on oil and gas industries, our economy is lagging behind the rest of the nation in recovery. The prospects for turning to the private sector for increasing support of our services are certainly affected by that.

The federal initiative can be important in mandating a nationwide attempt to identify families and youth in crisis. Accurate data collection and projection of at-risk populations will be necessary to assess needed new services and how they should be designed, implemented and funded. Once identified and when service delivery capacities are in place, there needs to be continuing demand for program evaluation and follow-up services to guarantee the effectiveness of the services delivered. Contrary to the opinion held by many, we believe in accountability. We agree that we should be able to demonstrate our effectiveness. We do ask that we be allowed to share, from our expertise and experience, what we would indicate as measure of success.

For my community, perhaps the most important contribution this committee can make in addressing the need for federal policies that address issues which significantly impact the health and well-being of the American family, is to link the intent of Congress in that regard as strongly to the work of the Labor and Commerce Departments as to the Departments of Health and Human Services, Housing and Urban Development, and Justice. Any national economic recovery which still leaves untouched what we have now come to call the hard-core, urban poor and unemployed will leave my community with as many families in crisis as ever. Particularly on behalf of the youth in our programs, but also on behalf of our Board of Directors and staff, I want to thank you for the opportunity to submit this testimony. I would like to invite you to visit Youth Alternatives, Inc. I would like to leave you with the words of a 17 year old former Greenhouse resident who lived on the streets for about three years. She told Greenhouse counselor, Claudia Dabbs, in an interview last year; "I added ten years to my life on the streets. You wonder how people can think you're young. I can't ever be the same again . . ."

STATEMENT OF ELLEN HOFFENBERG, PROGRAM DIRECTOR, GUARDIAN AD LITEM

Chairman **Miller**. Thank you.

Ms. **Hoffenberg**. Thank you. Mr. Chairman, members of the committee, I thank you for this opportunity to address you on the consequences of child abuse and neglect. My name is Ellen Hoffenberg. I am presently a child welfare attorney acting as director of the State of Florida Guardian ad litem program with the supreme court of Florida.

Our program coordinates the efforts of over 1,500 volunteer lay citizens who represent the victims of child abuse and neglect as guardians ad litem.

I would like to digress from my testimony, some of the members of the audience who may not know exactly what a guardian ad litem is. They are independent representatives appointed in all child abuse and judicial proceedings. The volunteer guardian ad litem in our program is a lay citizen, who investigates, monitors, protects, and reports on the child throughout the proceeding. Again, we are coordinating the efforts of volunteers to do this extraordinary service for children.

My comments are based on my professional experience, research on the consequences of child abuse and neglect and the program's volunteer experience with over 8,000 victims that we have represented since 1980.

I would like to begin with our knowledge of criminal offenders. I was introduced to child abuse as a public defense attorney representing a 16-year-old boy facing the death penalty for murder and rape of an 8-year-old child.

My investigation led me to the State of his birth and childhood. I learned of his rape at 3 years of age by his father, the beatings with a 2-by-4 board at age 5 by the mother resulting in brain damage, and rape and molestation at the age of 9, 12, and 14 by foster caretakers.

A psychiatrist and psychologist testified to his severe emotional disturbance and subsequent behavior as part of the battered child syndrome. The jury and prosecutor were unimpressed because the criminal system did not understand the child abuse in those days. In 1982, Florida recognized 80 to 90 percent of our prison population were abused as children. Seventy percent of sexual offenders have been victims of sexual abuse or trauma. We have yet to provide them with effective treatment. Florida is starting its first treatment program for children who commit sexual offenses and have histories of being sexually abused children. There will be 12 beds in this program. I am sure we will keep those beds full since Florida's training schools and delinquency programs alone house hundreds of untreated abused children.

Is there a relationship between spouse abuse and child abuse? In a research project reported in "Behind-Closed-Doors, Violence in American Families," it was found that spouse abuse is low for families with no children and increases with each additional child, being highest in families with 5 children, an incidence rate of 6 to 9 percent in a 2,000-family sample.

Additionally, they were related to the extent that children were abused, excuse me, spouses were abused 50 percent more in families that were also abusing their children. A large number of identified stressful events in families increase likelihood of spouse abuse and child abuse to between 33 and 50 percent of family interviewees with stressful events, including background information I have submitted to the committee. Abuse of pregnant wives was reported, directed to the unborn child.

Do children who are abused and neglected and remain untreated, engage in delinquent behavior? Guardians ad litem accept this as an undisputed fact. Abused children enter adolescence without the physical, educational, intellectual, and emotional skills and developmental progress necessary to cope with an otherwise difficult period of life. Child abuse and neglect damages a child's ability to exercise good judgment. An abused child perceives the world as a dangerous, hostile place—adults as persons who cause pain if trusted. Uncared for, these children will attempt to survive by any means. The value of a person's life and property are often meaningless because the child has learned he or she is of no value. Studies of Florida's children show that as much as 44 percent of the children reported in child abuse will be charged later as delinquents.

New York's Commission on Child Abuse found through a longitudinal study that one out of every two families sharing history of abuse of one child revealed delinquency offenses by a sibling.

Do child abuse victims engage in runaway, truant, or ungovernable behavior. Guardians ad litem, again who represent status offenders, often almost unanimously report long history of abuse and neglect. The Office of the Inspector General, Department of Health and Rehabilitative Services released preliminary findings which will be published at the end of the year. Although the findings are not surprising, they are worthy of recitation. The agency records of status offenders were reviewed. In addition to children being held in delinquent detention centers for status offense behavior, investigation showed 30 percent as having been abused or neglected, 20 percent as having committed crimes; 50 percent of these children have been diagnosed as learning disabled, mentally retarded or emotionally disturbed, 36 percent come from unstable homes; 40 percent having single parents.

Thirty percent of these children have been referred to the agency five or more times for intervention and help. The overwhelming reason for placing them in detention centers is lack of appropriate resources. Abused children enter adolescence without a stable connection to family, serious disruption of sexual identity development as a result of sexual abuse, with survival and coping mechanisms which dictate that running away from beatings is the only answer to parental abuse; and that pain and disappointment are best handled through abuse of alcohol and drugs. Their educational development has been significantly impaired at an early age, and they are unable to cope with the intellectual demands of a secondary school. The child's sexual abuse syndrome describes the sexually abused girl as having difficulty in school, engaging in runaway behavior, promiscuous and seductive. We are more likely to sympathize with a young person suffering child abuse. We discredit an adolescent's statement that she or he is being beaten or molested as an attempt to manipulate strict parents. We react to her hostility with further punishment. Yet, we should not be surprised that a child's unheeded call for help will result in a child who later distrusts a helping hand or is angered by a life of disappointment, physical violence, pain, and bitterness.

Having described the children and adult victims of child abuse who squeek the wheel or engage our attention because of antisocial behavior, I'd like to tell you about the quiet victim. As an inexperienced guardian ad litem, I learned to listen to the silent voice of child abuse when one of my clients committed suicide. Let's call him Johnny. Johnny was a handsome, 16-year-old adopted at the age of 12. The first 8 years of his life were an unbroken series of physical beatings by an alcoholic father. At 8, he was placed in a foster residence with 40 other children. His first adoptive father beat him, his second adoptive father died. Johnny's culture dictated a code of quiet suffering of pain.

When we tried to help Johnny, we underestimated the emotional damage and failed to reach out to his problems. When we ignored him, he wrote a letter to us that life was too painful and frightening and that he would rather die.

In my personal experience representing over 300 children, I have yet to meet a child who emerges from an abusive home without emotional scars, children who have no significant person they can consistently love—children who can't talk or walk because they are so emotionally traumatized, children whose emotional scars make them unable to make friends, the children who eventually take their own lives.

Waiting lists for child therapy are the equivalent of a lifetime for a child. It looks like we punish children for committing the crime of being abused—child abuse is rarely prosecuted. The child is taken from the home, placed in shelters with untrained persons unable to provide the extensive emotional support they need. Shelters often house up to twice as many children as they are licensed for. We have yet to identify or fully execute and fund an effective screening and training process for foster parents of abused children. A study completed in 1981 by the Institute of Criminal Justice on New York City's foster homes indicated that a substantial number of foster children are beaten while in care, often severely. Twenty-seven percent of foster parents interviewed use an object to discipline children. Guardian ad litem reports an alarming rate of sexual abuse by temporary care providers.

Children who are victims of child abuse face a system incapable of protecting child victims. If the cases are prosecuted, these children are often subjected to lie detector tests, repetitive questioning, sometimes by 20 or 30 different people, and are required to bear the traumas of the criminal justice system that leaves healthy adult victims with extensive psychological scars. Child witnesses are threatened by parents, are stigmatized, have their privacy continually invaded, and become emotionally and physically ill waiting for resolution of their cases.

Our children are often the ones that can't fit in a foster home or are hard to place. This is not surprising, since we don't have the diagnostic resources to accurately assess the extent of the emotional, intellectual, moral, and physical damage to the victim of child abuse. If we had these resources and had them quickly enough, it would not solve the problem since we don't have the skilled professional caretakers and treatment specialists in sufficient numbers to help the child overcome his or her individual problems. Communities that have these resources are often in a pilot stage, facing continual financial struggles and trying to provide too much with too little. If a program is available, most children are separated from natural families by hundreds of miles. Even if they receive help, they face a high probability of relapse, since they have not learned how to function outside of treatment and their parents have not participated in treatment to help their children succeed because of the large geographical distances. That is if a parent is available.

Guardian ad litem volunteers represent the most seriously abused and neglected children in the State. Out of 90,000 referrals in 1980, approximately 40,000 cases of reported child abuse and neglect are considered valid. Only 4,000 are brought to our attention. The overwhelmingly—overwhelming experience of these 4,000 children prove us unable to adequately treat the victims of child abuse and neglect.

There are many more that need court protection, but we have insufficient staff to adequately handle and investigate reports of abuse. By the time we try to help these children, they are often so physically and psychologically damaged that there is little hope we can restore a semblance of a normal life. I find it extremely saddening to be faced with a 3-year-old whose broken bones and mind have established a course of placement in numerous foster homes with future runaway, and possible criminal behavior.

Our volunteers' challenge is to fight the barriers of lack of funding, resources, and agencies unequipped to effectively intervene. The awareness of Americans has consistently been raised about identifying and reporting child abuse and neglect since you passed the Child Abuse and Treatment Act in 1975—our program has met your challenge to provide extraordinary advocacy for these children in our courts. We must effectively intervene now to provide quality support, guidance, and treatment for the multitude of children that we will be asked to help. There is no more deserving population. If we fail, our law enforcement, social service agencies, and courts will continue to expend energy and moneys attempting to afford temporary housing for the victims of today who inevitably will become the child abusers, sexual offenders, emotionally ill, and criminal offenders of tomorrow. There are thousands of caring professionals and volunteers waiting for the day we can succeed in preventing and treating child abuse and our children are waiting. Please do not let us all run out of time.

Thank you very much for the opportunity to present this to you today.

[Prepared statement of Ellen Hoffenberg follows:]

PREPARED STATEMENT OF ELLEN IRENE HOFFENBERG, ESQ., STATE PROGRAM DIRECTOR, STATE OF FLORIDA, GUARDIAN AD LITEM PROGRAM

Mr. Chairperson, members of the commitee:

Thank you for this opportunity to address you on the consequences of child abuse and neglect. My name is Ellen Hoffenberg. I am a child welfare attorney and presently direct the State of Florida Guardian Ad Litem Program of the Supreme Court of Florida. Our program coordinates the efforts of over 1,500 volunteers who represent the victims of child abuse and neglect as guardians ad litem. My comments are based on my own professional experience, research on the consequences of abuse and neglect and the Guardian Ad Litem Program volunteers' experience with over 8,000 victims that we have represented since 1980.

Let's begin with our knowledge of criminal offenders. I was introduced to child abuse as a public defense attorney representing a 16 year old boy facing the death penalty for the murder and rape of an 8 year old child. My investigation led me to the state of his birth and childhood. I learned of his rape at 3 years of age by his father; his beatings with a 2X4 at age 5 by his mother resulting in brain damage; rape and molestation at the ages of 9, 12, and 14, by foster caretakers.

A psychiatrist and psychologist testified to his severe emotional disturbance and subsequent behavior as part of the battered child syndrome. The jury and prosecutor were unimpressed because the criminal system did not understand child abuse in those days. In 1982, Florida recognized that 80 to 90% of our prison population were abused as children. 70% of sexual offenders have been victims of sexual abuse or trauma. We have yet to provide them with effective treatment. Florida is starting its first treatment program for children who commit sexual offenses and have histories of being sexually abused as children. There will be 12 beds. I am sure we will keep them full since Flroida's training schools and delinquency programs alone are housing hundreds of untreated abused children.

Is there a relationship between spouse abuse and child abuse? In a research project reported in Straus, Stimmet and Gelles book "Behind Closed Doors - Violence In the American Family" - it was found that spouse abuse is low for families with no children, and increases with each additional child, being highest in families with five children - an incidence rate of 6% to 9% in a sample of 2,000 families. A large number of identified stressful events in a family's year increased the likelihood of spouse abuse and child abuse to between 33% and 50% of families interviewee. Abuse of pregnant wives was reported as significanti due to marital stress or directed to the unwanted unborn child.

Do children who are abused or neglected and remain untreated engage in delinquent behavior? The Guardians Ad Litem who represent delinquent children accept this as an undisputed fact. Abused children enter adolescence without the physical, educationsl, intellectual and emotional skills and developmental progress necessary to cope with an otherwise difficult period of life. Child abuse and neglect damage a child's ability to exercise good judgment. An abused child percieves the world as a dangerous, hostile place - adults as persons who cause pain if trusted. Uncared for, these children will attempt to survive by any means. The value of a person's life and property are often meaningless because the child has learned that he or she is of no value. Two studies of Florida's children show that as much as 44% of children reported for child abuse will be charged with delinquent offenses. Studies in other states reveal as much as 86% of delinquent populations studied have histories of abuse or neglect as children. Child abuse is a disease that affects the whole family. New York's Select Commission on Child Abuse found that one out of every two families sharing a history of abuse of one child revealed delinquency offenses by a sibling.

Do child abuse victims engage in runaway, truant or ungovernable, i.e. status offense behavior? Guardians ad litem who represent status offenders almost unanimously report a long history of abuse and neglect.

The Office of the Inspector General, Department of Health and Rehabilitation Services, recently released preliminary findings on Florida's status offender population which will be published at the end of this year. Although the findings are not surprising, they are worthy of recitation. The agency records of status offenders were reviewed, in addition to children being held in delinquent detention centers for status offense behavior. Investigation of the records showed 30% having been abused and neglected, 20% having committed crimes, 50% of these children had been dignosed as learning disabled, mentally retarded or emotionally disturbed; 36% come from documented "unstable" homes; 40% having single parents. 30% of these children had been referred to the agency 5 or more times for intervention. The overwhelming reason for placement in detention centers is a lack of appropriate resources. Abused children enter adolescence without a stable connection to family; with a serious disruption of sexual identity development as a result of sexual abuse; with survival and coping mechanisms which dictate that running away from beatings is the only answer to parental abuse; and that pain and disappointment are best handled through abuse of alcohol and drugs. Their educational development has been significantly impaired at an early age and they are unable to cope with the intellectual demands of secondary school. An accepted evidentiary principle - the child sexual abuse syndrome - describes a sexually abused adolescent girl as having difficulty in school, engaging in runaway behavior, promiscuous and seductive. Our society is more likely to sympathize with a young victim of child abuse. We discredit an adolescent's statement that she or he is being beaten or molested as an attempt to manipulate strict parents. We react to her hostility and anger with further punishment. Yet, we should not be surprised that a child's unheeded call for help will result in a child who later distrusts a "helping hand" or is angered by a life of disappointment and physical violence, pain and bitterness.

Having described the children and adults victims of child abuse who "squeak the wheel" or engage our attention because of anti-social behavior, I'd like to tell you about the quiet victims. As an inexperienced guardian ad litem, I learned to listen to the silent voice of child abuse when one of my clients committed suicide. Let's call him Johnny. Johnny was a handsome 16 year old boy who was adopted at the age of 12. The first eight years of his life were an unbroken series of physical beatings by an alcoholic father. At eight, he was placed in a foster residence with forty other children. His first adoptive father beat him, his second died. Johnny's culture dictated a code of quiet suffering of pain. When we tried to help Johnny, we underestimated the emotional damage and failed to reach out and deal with his problems. When we ignored him, he wrote a letter to us that life was too painful and frightening and that he would rather die.

In my personal experience representing over 300 children, combined with our volunteers' experience, I have yet to meet a child, who emerges from an abusive home without emotional scars - children who have no significant person that they can consistently love, children who cannot talk or walk because they are so emotionally traumatized, children whose emotional scars make them unable to make friends, the children who eventually take their own lives.

Waiting lists for child therapy are the equivalent of a lifetime for a child. It looks like we punish children for committing the crime of being abused - child abuse is rarely prosecuted. The child is taken from the home and placed in shelters with untrained persons unable to provide the extensive emotional support these children need. Shelters often house up to twice as many children as they are licensed for. We have yet to identify or fully execute and fund an effective screening and training process for foster parents of abused children. A study completed in 1981, by the Vera Institute of Criminal Justice on New York City foster homes indicated that a substantial number of foster children are beaten while in care, often severely. 27% of foster parents interviewed use an object to discipline children. Guardians ad litem report an alarming rate of sexual abuse by temporary caretakers.

Children who are victims of child abuse face a system incapable of protecting child victims. If the case is prosecuted, these children are often subjected to lie detector tests, repetitive questioning - sometimes by twenty or thirty different people and required to bear the traumas of the criminal justice system that leaves healthy adult victims with extensive psychological scars. Child witnesses are threatened by their parents, are stigmatized, have their privacy continually invaded and become emotionally and physically ill waiting for resolution of a criminal case.

Our children are often the ones that cannot "fit" in a foster home or are "hard to place." This is not surprising, since we do not have the diagnostic resources to accurately assess the extent of emotional, intellectual, physical and moral damage to the victim of child abuse. If we had these resources, it would not solve the problem, since we do not have skilled professional caretakers and treatment specialists to help a child overcome his or her individual problems. Communities that have these resources are often in a pilot stage and facing continual financial struggles and trying to provide too much with too little. If a program is available in Florida, most children are separated from natural families by hundreds of miles. Even if they receive help, they face a high probability of relapse since they have not learned how to function outside of treatment and their parents have not participated in the treatment to help their children succeed. That is if a parent is available.

The Guardian Ad Litem volunteers represents the most seriously abused and neglected children in the state. Out of 90,000 dependency referrals in 1980, 40% or approximately 40,000 cases of reported abuse and neglect are considered valid. Only 4,000 of these cases are brought to the court's attention; the others are closed after one or two visits or an offer of services. The overwhelming experience of these 4,000 children prove us unable to adequately treat the victims of abuse and neglect.

There are many more that need court protection, but we have insufficient staff in the child welfare system to adequately handle and investigate reports of abuse. By the time we try to help these children, they are often so physically and psychologically damaged that there is little hope we can restore a semblance of a normal life. I find it extremely saddening to be faced with a 3 year old whose broken bones and mind have established a course of placement in numerous foster homes, and future runaway behavior,

Our volunteers' challenge is to fight the barriers of lack of funding, resources and agencies unequipped to effectively intervene. The awareness of Americans had consistently been raised about identifying and reporting child abuse and neglect, since you passed the Child Abuse Prevention and Treatment Act in 1975 - our program has met your challenge to provide extraordinary advocacy for these children in courts. We must effectively intervene - to provide quality support, guidance and treatment for the multitude of children that we will be asked to help. There is no more or deserving population. If we fail, our law enforcement, social service agencies and courts will continue to expend energy and monies attempting to afford temporary housing for the victims of today, who inevitably will become the child abusers, sexual offenders, emotionally ill, and criminal offenders of tomorrow. There are thousands of caring professionals and volunteers waiting for the day that we can succeed in preventing and treating child abuse - and our children are waiting. Please do not let us all run out of time.

BACKGROUND INFORMATION

Relationship between Spouse Abuse and Child Abuse

Murray A. Straus, Richard J. Gelles & Suzanne K. Steinmetz, Behind Closed Doors - Violence In The American Family, (New York: Anchor Books) 1980.

A national survey representative of American families -

Sample population: 2,143 families in 1976, interviews conducted with 960 men and 1,183 women; 1,146 having children between the ages of three and seventeen living in the home.

Relevant Findings:

Spouse abuse low for men and women with no children, increased with each additional child up to six, and nonexistent in homes with six, seven and eight children. Rate of wife abuse was between 0 and 4 % with no children at home; increasing from 4% to 6% for families with one to five children, and thereafter declining. Rates are higher for husband abuse reaching 9 % for amilies with 5 children.

Couples with the lowest family income showed the rate of wife abuse doubled from one to two child homes. For higher income groups the rate of husband-battering is three times greater in two-child than in one-child homes.

Parents of two children have rates of child abuse 50% higher than parents who have one child. The highest rate of child abuse exists in homes with five children.

Stress events identified: trouble with employment; arrest; death in the family; pregnancy or childbirth; serious sickness or injury; mortgage or loan foreclosure; serious health or behavior problem in family; sexual difficulties; financial problems; divorce and separation; move to another area; child problems with school or criminal behavior.

Relationship between delinquent behavior and child abuse

Department of Health & Rehabilitative Services, District 6 (Tampa) Florida:

Longitudinal study of children reported to HRS for child abuse since 1975 showed that 18.9% of these children were later referred for delinquent offenses.

Department of Health & Rehabilitative Services, Office of Evaluation of the Inspector General -

Study in 1980 of children reported to the system state-wide since 1978 showed that 35% of children referred to the agency for child abuse had later referrals for delinquent offenses. This figure represents a 22% incidence rate for children under 12 years; and 44% for children over 12.

Alfaro, Select Commission on Child Abuse, New York 1978 - a five year longitudinal study revealed:

a review of delinquent children referred to the system over a 20 year period showed that 17 to 23 % of those referred had been abused or neglected.

50% of families having a history of abusing one child show referrals of a sibling for delinquency behavior

Gluecks, Unraveling Juvenile Delinquents - a longitudinal study of 500 delinquent boys showed that they were twice as likely to bee known to the system for abuse and neglect. A history of abuse and neglect was found in 86% of the cases.

Study of Delinquency, Parental Psychoparthology and parental criminology, Connecticut - a study of 218 children, 8.6% of those with delinquent behavior were reported as abused and neglected as opposed to a 1% incidence rate of child abuse for non-delinquent children. 36% of the abuse required hospitatlization, for severe head or facial trauma.

Relationship between status offense behavior and child abuse

Department of Health andRehabilitative Services, Office of Evaluation of the Inspector General - in a study to be published in December 1983, preliminary rough findings indicate:

Random sample of HRS referrals of status offenders (300) and 20 children in detention centers:

30% had been previously referred for child abuse or neglect
30% had 5 or more referrals to HRS for intervention and assistance
50% had been in at least pone program prior to the referral, 50% in programs outside of the home, and 30 % in detention centers.
50% had diagnoses in the records for learning disability, mental retardation, emotional disturbance, or alcohol or drug dependence.

40% from families with mother present only (including live-in boyfriends but excluding step-fathers)

36% from unstable home environments

Judges responded that detention centers were used for placement of status offenders because there were no other programs available to protect the child.

State of Florida legislative findings in support of the Child Abuse Prevention Act , Florida Statute 827.075 (1982).

In 1979 the number of reported cases of sexual assault on children in Florida increased by 600%.

70% or more of all sex offenders have been the victims of a sexual assault or have experienced a sexual trauma during childhood

Studies of prison populations have indicated that as many as 80 to 90% of the inmates have been abused as children

65% of dependent children admitted to state hospitals in 1978 had histories of abuse and neglect

38% of children who were abused or neglected have later known histories of status offense or delinquent behavior

Child abuse is the reason 1500 children a year develop cerebral palsy as a result of brain damage and many children become mentally retarded.

The Legislature recognizes the costs associated with abuse and neglect not only with regard to the victimized child and family but also hidden costs of child abuse in later generations

Only 18 to 23% of abuse and neglect cases in a 2] year period were required voluntarily or involuntarily to receive counseling or services, and only 9% were judicially handled.

Speaking Up For Children

STATE OF FLORIDA
GUARDIAN AD LITEM
PROGRAM
the child representative
agency of the court

what is a guardian ad litem?

Thousands of abused and neglected children become the subject of judicial proceedings each year in Florida. Their voices are often unheard, and best interests overlooked in the complicated and overburdened adversary process. Guardians Ad Litem are citizens who volunteer to become part of a court program to represent the best interests of an assigned child. The volunteer Guardian Ad Litem is a representative for the child before the court, social service agencies and the community. He/she also protects the child during the family crisis, court proceedings, and follows the child's progress after the Court disposes of the case.

what does a guardian ad litem do?

The Guardian Ad Litem represents the best interests of the child in a variety of ways. The Guardian Ad Litem is an:

investigator	The Guardian Ad Litem independently conducts a thorough investigation on behalf of the child. He/she interviews many people: the child, counselors, pediatricians, psychiatrists and psychologists, mental health professionals, people from the neighborhood, schools, churches and law enforcement, and friends. The Guardian Ad Litem also examines and collects records from many sources concerning the child. The Guardian Ad Litem then takes this information to the experts in the community for recommendations on what is best for the child.
monitor	The Guardian Ad Litem serves as a monitor of the agencies and persons who provide services to the child. He/she assures that orders of the Court are carried out, and that families and children in need receive the help that they should.
protector	The Guardian Ad Litem protects the child from insensitive questioning and the often harmful effects of being embroiled in the adversary court process.
spokesperson	The Guardian Ad Litem assures that the child's wishes are heard, and that the best interest of the child is presented to the Court and agencies dealing with the child.

[redacted]

reporter The Guardian Ad Litem presents information to the Court and helps the Court determine what is in the child's best interest. He/she prepares a written report which becomes a permanent part of the child's record.

who assists the guardian ad litem in performance of his/her functions?

Each area has a local program coordinator who trains volunteers, matches cases and assists each Guardian Ad Litem in his work. Staff members assist the Guardian Ad Litem in preparation of reports and other material. Each program has a lawyer who advises volunteers on the protection of children's rights and represents the Guardian Ad Litem and the child in contested court proceedings. In addition, each program has a network of community resources and experts who are available to assist each Guardian Ad Litem.

who can be a guardian ad litem?

Any person who has common sense and good judgement can be a Guardian Ad Litem. A Guardian Ad Litem does not have to be a lawyer, counselor, therapist or parent, since he/she does not perform these roles for the child. A volunteer Guardian Ad Litem should be a person who has perhaps dealt with crises in his/her own life, and is capable of helping a child in crisis. He/she should be a person who CARES . . . and is able to give TIME to help a child. Volunteers will be matched with children depending on how much time they are able to give, the seriousness of the case, and the backgrounds of the volunteer and the child. Cases usually require from two to ten hours per week.

for further information contact:

Ellen Hoffenberg, Project Director
State of Florida Guardian Ad Litem Program
Office of the State Courts Administrator
Supreme Court Building
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GUARDIAN AD LITEM PROGRAM

In 1978, the Florida Legislature enacted Florida Statute 827.07(16) mandating the appointment of guardians ad litem to represent children in all abuse and neglect judicial proceedings. The 1980 Legislature funded a pilot project to be directed by the Office of the State Courts Administrator to report the effectiveness of three different models: representation by the Office of the Public Defender; private attorneys; and, volunteer lay citizens.

The Office of the State Courts Administrator began pilot testing a program utilizing lay citizen volunteer guardians ad litem in child abuse and neglect cases in August, 1980. The purposes of the project were: (1) to develop comprehensive training for volunteer lay citizens; (2) to implement several volunteer guardian ad litem projects within selected judicial circuits of the state; and, (3) to determine the comparative cost and quality effectiveness of three methods of Florida's guardian ad litem legislative mandate.

IMPLEMENTATION

By 1981, ten circuit programs had been implemented in the state. Project staff in the Office of the State Courts Administrator assisted circuit judges and court administrators in hiring and training staff, which included a local director (Circuit Coordinator), assistant, and program attorney. Each program is supervised locally by judges and court administrators, with the assistance of community advisory boards, and receives funding from the county for physical support of the program. Additional staff support is provided by local experts in the medical, mental health, law enforcement, and social work professions, who donate their time in training and advising volunteers. The program now functions in the following areas:

Circuit	Location	Counties Served
1st	Pensacola	Escambiia, Okaloosa, Santa Rosa, Walton
2nd	Tallahassee	Franklin, Gadsden, Jefferson, Leon Liberty, Wakulla
4th	Jacksonville	Clay, Duval, Nassau
6th	Clearwater	Pasco, Pinellas
7th	Daytona Beach	Flagler, Putnam, St. Johns, Volusia
8th	Gainesville	Alachua, Baker, Bradford, Gilchrist, Levy, Union
10th	Bartow	Hardee, Highlands, Polk
11th	Miami	Dade
12th	Sarasota	De Soto, Manatee, Sarasota
14th	Panama City	Bay, Calhoun, Gulf, Holmes, Jackson, Washington
17th	Fort Lauderdale	Broward

18th	Sanford	Seminole
	Titusville	Brevard
20th	Fort Myers	Charlotte, Glades, Hendry, Lee
	Naples	Collier

TRAINING AND EDUCATION

Comprehensive training manuals and curriculum were developed for instruction of project staff and individual volunteers appointed to represent children. An audio-visual program was developed to assist in public education and awareness of the problems of abused and neglected children, and the need for providing quality representation to children in court proceedings. With the assistance of program brochures, the audio-visual presentation was used to recruit members of the community interested in serving as guardians ad litem.

Staff training manuals outline the methods of implementing local programs, public education and recruitment, selecting and supervising volunteers, and the use of community resources. Volunteer manuals instruct volunteers on the role and responsibilities of guardians ad litem, skills necessary to perform duties, and the types of resources available to the court for helping children. Volunteers also receive in-depth training from staff in areas identified in the project's training curriculum.

The program is presently developing a revised manual of minimal standards for operation and procedures, curriculum, and legal services.

EVALUATION

During the first year of program implementation, independent evaluators determined that the volunteer model was the most cost effective based upon the data presented from 600 cases. Volunteer guardians ad litem performed five major roles for the child and court in each case:

Investigator: Volunteers conduct numerous hours of independent investigation on behalf of the child. Such include interviews with medical professionals, mental health staff, sources in the neighborhood, the child's family, school officials, law enforcement personnel, and the child. As well, volunteers collect and review numerous records and documents. Over 60 percent of volunteer time is spent investigating the allegations of child abuse and neglect and preparing recommendations to the court.

Monitor: The volunteer assures that agencies and persons provide services or communicate with the child properly, in addition to assuring that orders of the court are carried out.

Protector: The volunteer protects the child from insensitive questioning and the often harmful effects of being embroiled in the adversary court process, and assures that legal counsel in the program represent the child in contested legal proceedings.

Spokesperson: The volunteer assures that the child's wishes are heard and that the best interest of the child is presented to the court and agencies dealing with the child. Volunteers spend significant time providing emotional support to the child during the difficult judicial process.

Reporter: The volunteer presents information to the court in a written form at each hearing in the proceeding to assist the court in determining what is in the child's best interest.

Continued evaluation has shown that volunteer guardians ad litem provide necessary services to the court and the child, especially in the areas of monitoring the child's progress and locating more effective resources for the child and family, or more beneficial temporary placements for the child in the community. The latter benefit saved the state monies in excess of the cost of the pilot project.

The guardian ad litem is viewed as an officer or "arm" of the court, who presents an independent, objective analysis of the facts to the judge prior to decision-making. Local supervision of the program assures that staff and volunteers meet the needs of the juvenile judge and children in varying communities of the state.

The program was found to have several humanistic benefits. Volunteers have become more aware of local child abuse and neglect problems and judicial proceedings. Each volunteer spends countless hours in service to needy children in the juvenile system. Additionally, volunteers bring prior professional and life experiences to bear in helping children, and provide an intelligent, thorough, common-sense approach to resolution of family problems. They unite children with relatives (previously unknown to local agencies) who provide more caring environments for the child as opposed to institutional placements. When children are placed by the court back in the home of parents suffering from problems, the volunteer assures that the child is not further endangered, and that the family receives necessary services from community agencies.

Evaluators concluded that the pilot project should be implemented throughout the state in a permanent status. Their recommendation was favorably accepted by the Legislature in 1982.

SUMMARY

The State of Florida Guardian Ad Litem Program is a unique approach to providing independent representation to children and needed information and assistance to juvenile judges. The program has established minimum standards for screening, training, and supervising volunteers to assure quality performance. State technical assistance and coordination have provided continued staff training, communication between programs, and ongoing data collection and case management of geographical, cultural, and economic problems faced by each program.

To date the program has recruited and trained over 900 volunteers who have represented 4,000 children in need.

Prepared by: Ellen I. Hoffenberg, Esq.
State Program Director
State of Florida Guardian Ad Litem Program

Revised 1 April 1983

STATEMENT OF MARIO JARDON, EXECUTIVE DIRECTOR, NORTHWEST DADE COMMUNITY MENTAL HEALTH CENTER, INC.

Mr. JARDON. Thank you very much for giving me the opportunity to present this testimony today. I would like to simply highlight the major points of my statement.

Chairman MILLER. Thank you.

Mr. JARDON. First I direct a community mental health center serving a population of about 250,000. In any given year, we see about 2 percent, or 5,000 clients. We are averaging about 80,000 face-to-face encounters in a year.

As against this background, on my way here I asked myself what is the problem, so I could share with you the one I need the most help with, sort of speaking before God. That problem has to do with children that I think Ms. Hoffenberg has referred largely to in her presentation. I am talking about children who, before or after being exposed to institutions, have no place to go.

I am talking about children who, for instance, are homicidal, wish to kill their mothers, cannot remain in the home. The mother is a rather poor person, has other children in the family, teenagers out of school, preschoolers, so on and so forth. And the child then cannot remain in the home. We are also talking about children who have failed in school, have learning problems, so on and so forth.

I am also talking about children we see in emergency rooms, throughout patient care, et cetera, who come after years of exposure or life in an institution or foster care, still with very severe learning disabilities, very severe emotional disturbances, cannot be managed in the school system; their parents, not having means to take care of them.

And the children are given to us by agencies of the State's Department of Health and Rehabilitative Services as being mentally ill. They are not mentally retarded and, therefore, would not qualify for other programs given to the mentally retarded. Yet we have children who have no place to go. And that is the issue, no place to go.

A word about the system and why the system is incapable of taking care of these children. As good as the original Community Mental Health Systems Act was in developing a program that has made a major impact in the Nation in terms of reducing the level of tertiary care, that is, meeting the needs of the mentally ill soon enough so as to prevent major disability, it is obvious to us now, after 20 years, that the original act did not contemplate the needs of populations such as these.

The act provided for outpatient care, inpatient care, care for people who had levels of skills or some resources that could be maintained in the community. It did not quite address the needs of very dependent populations, adult or children. The children that I am addressing here, while the community health system developed, largely were taken care of by State psychiatric hospitals, during the initial phases, by foster care systems, and in many cases, by private-run residential programs.

All of these, due to one reason or another, are not doing the job anymore. To begin with, private programs can really impose very selective criteria. Believe it or not, there are children who fail the criteria of many programs. So the child can no longer be in a program and is given back to the State for someone to take care of.

Foster care is used effectively in some short-term situations, but frankly it cannot work when the major agenda that both the child and family has is really not to fall in love with each other, because it is considered to be a temporary arrangement.

State psychiatric hospitals, we know, have been the object of a major policy to be, if not eliminated, at least reduced in scope because children who go to institutions really do not develop the living skills necessary to become as productive or independent as possible. The problem, as we face it today, is that we have no alternative.

We have an established purchase of services case review committee that meets biweekly. At any point in time it would have easily 20 children afflicted by the most severe conditions for whom we find no homes. As pointed out in my written testimony, the entire State of Florida maintains 87 children. From Dade County, we have 87 children out of 390,000 in placement.

In terms of other statistics that we know of, this ratio of less than 2 per 10,000 is really ridiculous. What it shows is that we simply do not have the facilities. When this case review committee meets to discuss new cases coming up, there is no alternative. There is no place to go. We have 18 in the State psychiatric hospital, 9 placed out of State. There isn't one more dollar. No place to go for these children.

Meanwhile, new children are constantly identified by the school systems, by juvenile courts, by HIS agencies as needing immediate and long-term care. There is no place to go, no place to go.

So I came with a wish, a wish that I think is very cost effective and has tremendous potential for alleviating pain in the lives of so many of these children who really are not being taken care of by anyone else in society. We know the State pays in excess of $4.8 million in out-of-State placements. From Dade County alone, we know about $1.7 million are used to pay for out-of-State placements.

If only we had a residence in the county, if only we had a facility which is what the private entrepreneurs have, the capital. After all of the years through the 1960's and 1970's, after all of the grand years that we have had, the Federal Government's seed money concept really never planted trees. There were never any big roots to those Federal programs. We never purchased or acquired facilities.

In these kind of programs, the facility together with the staffing is what makes the program. I can assure you that a one-time grant of no more than $1 million will provide easily for 40 beds, which I am sure we could negotiate with the State of Florida in terms of their providing the operational funds. In other words, we simply would then contract with the State to provide those beds in this community for those children who are out of State, State psychiatric hospitals, and going nowhere.

We will get then the operational funds to run the facility. The State would regulate its use. And I am sure that we would alleviate tremendous pain and tremendous human loss. That is my wish.

[Letter from Mario Jardon follows:]

THE NORTHWEST DADE COMMUNITY MENTAL HEALTH CENTER, INC.,
Hialeah, Fla., October 12, 1983.

Mr. Chairman George Miller and Members of the House Select Committee on Children, Youth and Families, I am pleased to have this opportunity to give testimony on behalf of children and families of Dade County.

There is consensus in the public mental health field about what can, and should be, done in these times of reduced Federal spending and economic recession. The first priority for public funding sources is to serve those in direst need. Need in this context is defined not only in clinical terms based on the acuteness or the chronicity of the child's or family's syndrome, but also, in terms of the socio-economic characteristic that often are associated with severe illness. Children who are born in poverty without parental support, are learning disabled or other whose organically impaired, certainly need more assistance than others who are not confronted by the same ills.

Need also must be defined from the perspective of what it is that the present system of care can, or cannot do, for the neediest of children and their families. After 20 years of the passing of the Community Mental Health Act by the late President John F. Kennedy, we find a community based system consisting mostly of outpatient psychiatric care, inpatient care in some cases and certainly little, if any, residential care. Currently 87 out of 390,000 children of Dade County, are placed in institutions. Eighteen of these reside at the State Psychiatric Hospital, nine are placed out of State, which begins to give an indication that the issue is not that children of Dade County do not require residential placement but that there is hardly anything available. At any given point in time over 20 children afflicted by the most severe conditions languish for months in the waiting lists of the State's established Purchase of Services Case Review Committee.

The State of Florida already spends about $4,380,000 in maintaining present placement slots. In view of the demand for funding from so many other underserved groups, little relief can be expected short of the State's passing an income tax. An implausible possibility. Yet the State of Florida spends about $1.7 million in out of State placements, which moneys could be used for maintenance of residences for children in our communities assuming that the facility is available.

Thus, a pattern emerges for the revival of old alliances between Federal, State and local agencies. As with the original Community Mental Health Act, construction moneys could be made available. A one time grant of $1 million to Dade County would provide minimally 40 beds for short term and long term care purposes, which likely would be financed operationally by the State.

This problem of homeless, dependent children takes place nationwide. Let the Federal Government provide a home; let the States regulate and fund its operation and let us local, concerned workers have the opportunity to give these children a chance for a good life.

Sincerely,

MARIO E. JARDON, L.C.S.W.,
Executive Director.

STATEMENT OF ANA RIVAS-VAZQUEZ, CLINICAL DIRECTOR, CHILDREN'S PSYCHIATRIC CENTER

Chairman **MILLER**. Thank you.

Dr. **RIVAS-VAZQUEZ**. Mr. Chairman, on behalf of the children and families of Dade County, I am pleased to give a brief report of the services that the Children's Psychiatric Center, in conjunction with the Northwest Dade Community Mental Health Center, provide to a segment of our population in this county. The Children's Psychiatric Center is a large private, nonprofit organization which has served approximately 1,300 children and their families this past year.

The Markenson Unit, of which I am director, and whose figures and programs I will be presenting to you, is only one of the agency's three clinics. We are located in a highly Hispanic populated area and have served this past year over 500 children and their families and have in addition to that a rather incredible waiting list.

At present, our active caseload is 240 families which include 860 individuals. During this past month of September, we opened 31 new cases of which 30 were Hispanics and 1 was Anglo. The ethnic breakdown by country of origin was: 23 Cuban, 4 Colombian, 1 Chilean, 1 Mexican, and 1 Nicaraguan.

The range of our services include outpatient psychotherapeutic treatment, both individual and family, outreach services to 5 schools in our area and 10 other schools in the area that are desperately asking us for services, educational programs for parents, psychiatric consultations and an adolescent day care center.

In the short 3 years which we have worked in close association with the Northwest Dade Community Mental Health Center, we have developed a whole array of needed programs to serve our very needy and deprived community. We developed a summer acculturation camp, a therapeutic nursery, a therapeutic group home for girls, and independent living pilot project for 18- to 21-year olds, as well as an adolescent treatment center. Due to cuts in funds, all of these special programs, with the exception of the adolescent treatment center, are defunct at present.

Yet the need has not ceased and by no means is abating in terms of the political reality in Latin America. I am a Cuban American that came to this country 23 years ago. Initially the big influx was of Cubans. Right now we are getting South Americans, Central Americans, Nicaraguans, people from all over the country. They are here. We have to listen to them.

Please let us not think of this as a need of an interest group, but as a mental health priority. The influx and migration to our shores has not stopped. These groups all have specific needs and characteristics that we need to address. Have no doubt that we are talking about a population at risk with many extremely emotionally disturbed youngsters going through the traumatic experience of acculturation, of migration and resettlement.

Help them now and rather than seeing them go to jails or mental hospitals, let us aid them in becoming productive citizens in this free society. The reality is dramatic, but the choice is simple. Pay now or pay later. Pay now; that is, provide adequate programs on a priority basis for these minorities, or pay later in bigger and more inflated dollars when the taxpayers will then have to bear the brunt of delinquency, crime and mental illness.

[Prepared statement of Ana Rivas-Vazquez follows:]

PREPARED STATEMENT OF ANA A. RIVAS-VAZQUEZ, PH.D., CLINICAL PSYCHOLOGIST AND CLINICAL DIRECTOR, MARKENSON UNIT, THE CHILDREN'S PSYCHIATRIC CENTER, INC.

On behalf of the children and families of Dade County, I am pleased to give a brief report of the services that The Children's Psychiatric Center, in conjunction with the Northwest Dade Community Mental Health Center, provide to a segment of our population in this County. The Children's Psychiatric Center is a large private, non-profit organization which has served approximately 1,300 children and their families this past year. The Markenson Unit—of which I am Director—and whose figures and programs I will be presenting to you—is only one of the Agency's three clinics. We are located in a highly Hispanic populated area and have served this past year over 500 children and their families. At present our active case load is 240 families which include 860 individuals. During this past month of September, we opened 31 new cases of which 30 were Hispanics and one was Anglo. The ethnic breakdown by country of origin was: 23 Cuban, 4 Colombian, 1 Chilean, 1 Mexican and 1 Nicaraguan. The range of our services include out-patient psychotherapeutic treatment—both individual and family—outreach services to 5 schools in our area, educational programs for parents, psychiatric consultations, and an adolescent day care center.

In the short 3 years which we have worked in close association with the Northwest Dade Community Mental Health Center, we have developed a whole array of needed programs to serve our very needy and deprived community. We developed a summer acculturation camp, a therapeutic nursery, a therapeutic group home for girls, and Independent Living Pilot Project for 18 to 21 year olds, as well as an Adolescent Treatment Center. Due to cuts in funds all of these special programs with the exception of the Adolescent Treatment Center are defunct at present. Yet the need has not ceased and by no means is abating in terms of the political reality in Latin America. Please let us not think of this as a need of an interest group, but as a mental health priority. The influx and migration to our shores has not stopped. These groups all have specific needs and characteristics that we need to address. Have no doubt that we are talking about a population at risk with many extremely emotionally disturbed youngsters, going through the traumatic experience of migration and resettlement. Help them now, and, rather than seeing them go to jails or mental hospitals, let us aid them in becoming productive citizens in this free country. The reality is dramatic, but the choice is simple. Pay now, or pay later. Pay now—that is, provide adequate programs on a priority basis for these minorities—or pay later in bigger and more inflated dollars when the tax payers will then have to bear the brunt of delinquency, crime and mental illness.

STATEMENT OF MARIE MITCHELL, COORDINATOR, TEEN SERVICES PROGRAM, GRADY MEMORIAL HOSPITAL

Ms. MITCHELL. Mr. Chairman, I am Marie Mitchell. Thank you very much for asking me to testify about helping young people postpone sexual involvement. Teenage pregnancy is a serious national problem affecting every community in the United States. Young people who give birth at an early age are more likely to have complications during pregnancy, to die in childbirth and to have a low birth weight baby, which is associated with mental retardation, than are women who give birth in their 20's.

The health outcomes are just one aspect of teenage pregnancy. Pregnancy for the young girl is also an emotional experience, one that affects her view of herself, her relationship with others and her attitude toward a child. There are educational vocational outcomes as well.

The young mother who is provided with education during pregnancy and encouraged to return to school following the birth of her baby is much more likely to finish school and, therefore, much less likely to experience unemployment, underemployment, and welfare dependency.

Grady Memorial Hospital has long been concerned and involved with the problem of teenage pregnancy. It was the site of one of the first maternal and infant care projects funded in the country, charged with providing care to higher risk women who are pregnant. It established a specialized service for all adolescents 15 and under who became pregnant, as well as a service to provide family planning services to adolescents 16 and under who gave birth to a baby.

The department of gynecology and obstetrics at Emory University, working with Grady Hospital and the Atlanta public school system, also began the first pilot program in a major school system that permitted pregnant girls to remain in school with special supports. Following this pilot program, the Atlanta public schools passed a resolution making them the first major school system in the country to permit pregnant girls to remain in their regular classroom.

Since that time, Grady Hospital has put increased effort into pregnancy prevention. In 1976, we entered into a formal agreement with Atlanta public schools to provide human sexuality education to all eighth grade students, with the goal by 1981 to have educated all 13- to 16-year-old children in the school system, some 21,000 young men and women. Hence, the Atlanta community is one in which commonly proposed solutions to teenage pregnancy, sex education, and birth control are already in place and having whatever impact they can have.

The fact that the teen pregnancy rate has been reduced since implementation of these services show that such services are necessary and can have some effect. Indeed, Fulton County, which includes Atlanta, has lower pregnancy rates than the rest of Georgia as a whole.

The fact that the teen pregnancy rate remains unacceptably high, however, probably means they are not totally sufficient for dealing with the problem. "Postponing Sexual Involvement," an education series for young people, age 13 to 15, is a new approach aimed at reducing teenage pregnancy by reducing the number of teens that become sexually involved.

Developed by the teen service program of Grady Hospital and the department of gynecology and obstetrics at Emory University, the "Postponing Sexual Involvement" series is being offered to schools and community groups throughout the State of Georgia beginning in the late fall of 1983.

The "Postponing Sexual Involvement" series does not offer factual information about reproduction, nor does it discuss family planning. It concentrates on the social and peer pressures which lead youth into early sexual behavior. Its major emphasis is on building skills which help young people deal with these pressures.

One of the main ways in which postponing sexual involvement differs from most sex education programs is that it starts with a given value. You ought not to be having sex at a young age. Everything in the series is designed to reinforce this value. All information, exercises, and skill building are aimed at helping the young person carry out the decision not to have sex at a young age.

Another principal difference in this approach is most sex education programs currently being used in this country use a decisionmaking model. Young people are asked to consider facts, alternatives, and make choices based on consideration of these and possible outcomes or consequences. Such a model may indeed be the most appropriate one for older students. However, according to noted psychologist Piaget and other theorists, the ability to move from concrete to operational thinking and, therefore, to make decisions based on future orientation, starts somewhere around the age of 11 and is not complete until about age 15 or 16.

Thus, those providing information to adolescents 16 and under about human sexuality and family planning may be facing a group with diverse cognitive development. Some young people may well be able to grasp and apply the decisionmaking model which hinges heavily on weighing alternatives and consequences and making choices based on the ability to conceive the future. Others may find such a model too advanced for their cognitive state.

The challenge for us, then, became to develop another teaching, information-giving tool to help young people protect their fertility and act responsibly until such a time as they are cognitively able to apply a full decisionmaking approach to their sexual choices. The need for a curriculum such as the "Postponing Sexual Involvement" series, which aims at helping young people 15 and under gain skills to deal with both early sexual maturity and social and peer pressures, is made more imperative by the fact that the average age of fertility among young women has now dropped to about 12½, and the age at first intercourse is also earlier than it had previously been.

A study done in 1979 by Kantner and Zelnik indicated that 22.5 percent of 15-year-olds at that period had already had intercourse, up from 14.7 in 1970. Through funds granted by the Georgia Department of Human Resources, the Mary Reynolds Babcock Foundation, Cleveland Foundation and George Gunn Foundation of Cleveland, the series "Postponing Sexual Involvement" was field tested on approximately 1,500 people in Atlanta, Ga., and Cleveland, Ohio.

The goal of the field test was to ascertain acceptance level by both the community and participants, as well as to learn what delivery styles are most effective. Preliminary findings indicate that while the series can be effectively led by an adult leader or peer leaders, peer leaders are most effective. The young participants of the series understandably identify more with their peers. They felt the peer leaders were going through and experiencing many of the same feelings and pressures they were experiencing.

Other findings of the field test indicated that the series is effective when used in a variety of settings, such as girls clubs, boys clubs, housing projects, schools, or church groups. Acceptable and effective with a variety of ethnic and socioeconomic groups, effective with girls groups alone and boys groups alone, but it was thought to be most effective when the young groups were combined.

The "Postponing Sexual Involvement" series also has an important parental involvement component that was tested. In half of the field test sessions parents were asked to participate. They received the same information and went through some of the same exercises as the young people did, but in separate rooms. The purpose of this was based on experiences with other educational programs.

For example, when the new math was first implemented in public schools, a whole generation of parents was frustrated and upset about not being able to help their children with their homework. We felt that if we were attempting to give young people a new mindset about postponing sexual involvement we needed to share that with parents. It is our expectation that parents would not only acquire a better understanding of the implications of the sexual pressures young people are experiencing, but also become reinforcement agents for the series.

The series on how to say no was designed to provide young people with tools to help them bridge the gap between their physical development and their cognitive ability to handle the implications of such development. It was not designed to replace the provision of factual information about human sexuality and family planning.

It is our feeling that teens who decide not to have sex get little support and few rewards from agencies and others for their behavior. Programs and support systems are designed for those who have sexual intercourse and/or become pregnant, not for those who don't. The "Postponing Sexual Involvement" series can, at a minimum, strengthen the resolve of young people who have already decided they don't want to become sexually involved and make them feel supported in their decision.

For those who are ambivalent about beginning to have sexual intercourse, it can help them develop attitudes and skills which will assist them in postponing sexual activity. It can also help sexually involved young people. A random survey of the Emory/Grady Teen Services clinic population of sexually active girls 16 and under showed surprisingly that what they most wanted information on was how to say no without hurting the other persons feelings. Thus, the curriculum also has the potential for helping these young people communicate more effectively in their current and future relationships.

Thank you very much.

[The prepared statement of Marie Mitchell follows:]

PREPARED STATEMENT OF MARIE E. MITCHELL, R.N., PROGRAM SUPERVISOR, TEEN SERVICES, GRADY HOSPITAL, ATLANTA, GA.

Mr. Chairman and members of the committee, I have been asked to testify about helping young people postpone sexual involvement because teenage pregnancy is a serious national problem affecting every community in the United States. Young people who give birth at a young age, are more likely to have complications during pregnancy, to die in childbirth, and to have low birth weight babies which is associated with mental retardation, than are women who give birth in their twenties.

The health outcomes are just one aspect of teenage pregnancy. Pregnancy for the young girl is also an emotional experience, one that effects her view of herself, her relationships with others, and her attitude toward her child. It is especially imperative for the young person that the pregnancy be a positive experience. How the young mother feels about herself is often dependent upon the support and attitudes conveyed to her by those she is most in contact with: family, relatives, friends, those in youth-serving institutions such as schools. How the young mother feels about herself directly influences how she will view her child and her parenting role.

There are educational/vocational outcomes as well. The young mother who is provided with education during pregnancy and encouraged to return to school following the birth of her baby is much more likely to finish school and therefore much less likely to experience unemployment, underemployment and welfare dependency.

Often in our attempt to label problems and develop programs to meet them, we arbitarily segment our view of people—in this case teenage girls and boys. We tend to forget the pregnant teenager, the prospective young father were only a few months before part of the mainstream of other teenagers. We tend to forget the young teenage mother of today before that was one of the many teens who are tempted to engage in sexual activity at an early age. The young person is one and the same and at whatever stage she or he is in, she or he needs our concern and help. Programs need to be designed and implemented around all aspects of teenage sexuality, teenage pregnancy, and parenthood. In that process we must be particularly aware of the fact the one unit that is always involved with the young person is the family and it is the family's support that often is the final factor in making a difference in outcomes for young people.

For example, of those single teen mothers who lived with parents or relatives, 62 percent were graduated from high school, compared to just 41 percent of those who lived alone; 60 percent got jobs, compared to just 41 percent of those who lived alone, and only 43 percent received welfare assistance, compared to 65 percent of the young mothers who lived away from their parents. When grandparents or the father of the child helped the teenager care for the baby, the child's cognitive development was found to be superior to that of children brought up by a young mother alone.

The family's important role is one of the reasons in designing the educational series "Postponing Sexual Involvement" which I am about to discuss, that we structured a component to help parents better help their young people resist pressures to become sexually involved and therefore help protect them from pregnancy and sexually transmitted diseases.

Mr. Chairman and members of the committee, Grady Memorial Hospital has long been concerned with and involved with the problem of teenage pregnancy. Grady Hospital was the site of one of the first Maternal and Infant Care Projects funded in the United States. Charged with providing care to high-risk women who were pregnant, it established a specialized service for all adolescents 15 and under who became pregnant. Its also established an interconceptional care program to assist all adolescents 16 and under who gave birth to a baby with future family planning needs. The Department of Gynecology and Obstetrics at Emory University working with Grady Hospital and the Atlanta Public Schools also began the first pilot program in a major school system that permitted pregnant girls to remain in school with special supports. Following this pilot program, the Atlanta Public Schools passed a resolution making them the first major school system in the United States to permit pregnant girls to remain in their regular school classrooms.

Since that time Grady Memorial Hospital has put increased efforts into pregnancy prevention. The interconceptional care program was changed to the Teen Services Program and a thrust toward prevention of the first pregnancy was added to the effort of prevention of second pregnancies among adolescents. The Teen Services Program in 1976 entered into a formal agreement with the Atlanta Public Schools to provide human sexuality education to all eighth grade students—the goal by 1981 to have educated all 13 to 16-year-olds in the Atlanta Public Schools, 21,000 young men and young women.

Hence, the Atlanta Community is one in which commonly proposed solution to teen pregnancy (sex education and birth control) are already in place and are having whatever impact they can have. The fact that the teen pregnancy rate here has been reduced since implementation of these services shows that such services are necessary and can have some effect. Indeed Fulton County (Atlanta) has lower pregnancy rates than the rest of Georgia as a whole. The fact that the teen pregnancy rate remains unacceptably high, however, probably means they are not sufficient for dealing with the problem.

"Postponing Sexual Involvement: An Education Series for Young People Age 13–15" is a new approach aimed at reducing the teenage pregnancy rate by reducing the number of teens who became sexually involved. Developed by the Teen Services Program of Grady Memorial Hospital and the Department of Gynecology and Obstetrics at Emory University. The Postponing Sexual Involvement series is being offered to schools and community groups throughout the state of Georgia beginning in late fall 1983.

The "Postponing Sexual Involvement Series" does not offer factual information about reproduction, nor does it discuss family planning. It concentrates on the social and peer pressures which lead youth into early sexual behavior, and its major emphasis is on building skills which help young people deal with these pressures.

One main way in which the Postponing Sexual Involvement curriculum differs from most sex education programs is that it starts with a given value: "You ought not to be having sex at a young age." Everything in the series is designed to reinforce this value. All information, exercises, and skill building are aimed at helping the young person carry out the decision not to have have sex at a young age. Although traditional sex education programs often implicitly have that as a hoped-for outcome, they generally include information on birth control so that if the young people do choose to have sex, they can behave responsibly. This Series avoids the double message implicit in such programs.

Another principal difference is in the approach. Most sex education programs throughout the country (and the one employed by the Teen Services Program in the Atlanta Public Schools) use a decision-making model. Young people are asked to consider values, facts, and alternatives and then make choices based on consideration of these and possible outcomes or consequences. Such a model may indeed be the most appropriate one for older students. However, according to noted psychologist Piaget and other theorists, the ability to move from concrete to operational thinking (and, therefore, to made decisions based on a future orientation) involves a gradual shift starting somewhere around 11 and not completed until about age 15 or 16. Thus those providing information to adolescents 16 and younger about human sexuality and family planning may be facing a group with diverse cognitive development. Some of the young people may well be able to grasp and apply the decision-making model (which hinges heavily on weighing alternatives and consequences and making choices based on ability to conceive the future); others may find such a model too advanced for their cognitive stage.

The challenge thus becomes to develop other teaching information-giving tools to help young people their fertility and act responsibiy until such time as they are cognitively able to apply a full decision-making approach to sexual choices. The need for a curriculum such as the Postponing Sexual Involvement Series, which aims at helping young people (15 and younger) gain skills to deal with both early sexual maturity and social and peer sexual pressures, is made more imperative by the fact that the average age of fertility among young women has now dropped to 12.5, and the age at first intercourse is also earlier that it has previously been. A 1979 study by Kantner and Zelnik indicated that 22.5 percent of the 15-year olds at that period had already had intercourse (up from 14.7 percent in 1970).

The Postponing Series is different, too, in that it is not based, as are many sex education programs, on the notion that knowledge alone can change behavior. That this notion is not always so is seen clearly from smoking behavior. Despite widespread knowledge that smoking causes cancer, millions of people still smoke. Hence, the Series emphasis is not on knowledge itself, but on participatory exercises, skill building, reinforcement, and practice.

Another contrast is that the Series does not use the "role plays" common to many sex education programs, in which young people experience being in a situation before it happens to them and, in an open-ended framework, play out to whatever conclusion emerges. Role plays are an excellent teaching tool, but since the Postponing Series is designed to support one value, role plays are not used on the chance that the result might not reinforce the desired value of postponment. Instead, young people are given a situation similar to one might be given in a role play, but are told to write a skit in which the lead character (male or female) has to say "no" to the pressure he or she is receiving.

Through funds granted by the Georgia Department of Human Resources, The Mary Reynolds Babcock Foundation, The Cleveland Foundation and the George Fund Foundation, The Series on Postponing Sexual Involvement was field tested on approximately 1500 people in Atlanta, Georgia and Cleveland, Ohio. The goal of the field test was to ascertain the acceptance level by both the Community and the participants (parents and young people), as well as to learn what delivery styles are most effective. Our preliminary findings indicate that while the series can be effectively lead by an adult leader or peer leaders—peer leaders are most effective. The young participants in the series understandably identified more with the peers. They felt the peer leaders were going through and experiencing many of the feelings and pressures they are experiencing.

Other findings of the field test indicated the series is: effective when used in a variety of settings (Girl's Clubs, Boy's Clubs, housing projects, schools or church groups); acceptable and effective with a variety of ethnic and socio-economic groups; and effective with girl's groups alone and boy's groups alone, but was thought to be the most effective when the groups are combined.

The Postponing Sexual Involvement Series also has an important parental involvement component that was tested. In half of the field test sessions, parents were asked to participate. They received the same information and went through the same exercises as the young people did (but in a separate room). The purpose of this was based on experiences with other educational programs. For example, when the "new math" was first implemented in the public schools a whole generation of parents were frustrated and upset about not being able to help their children with their homework. We felt that if we're attempting to give young people a new "mind-set" about postponing sexual involvement, we need to share that with the parents. It was our expectation that parents would not only acquire a better understanding of the implications of the sexual pressures young people are experiencing but would also become reinforcement agents for the series.

Thus far, interim field-test results show overwhelmingly positive community response to this program. Many community groups, including several church groups, have found the Series to be the first program acceptable to them and have eagerly asked to have it given to their parents and young people. We have also found the parents to be enthusiastically responsive. To this point, no parents have refused to let their child be involved, and they have been among those most likely to call on behalf of their church, school or other organization asking to have a Series presented. In sessions where parents are invited to participate, at least half have attended. In this time of working parents, small nuclear families, and single-parent households, we feel that having over half the parents participate in The Series is extraordinary. We have also had a good response from the young people themselves who indicate that they have been made more aware of the sexual pressures they receive and feel more confident in their ability to respond to pressure One-year field test follow-ups will help us learn more about what parents, young people, and particpating groups feel the impact of the the Series has been.

Structure and content: The Series is divided into four sessions, each one and one-half hours long. The first three sessions are given fairly close together, either on the three consecutive nights or once a week on three consecutive weeks. The fourth session is given as a reinforcement session anywhere from three to six months later.

The first session presents information and exercises relating to social pressure. Participants are given opportunities to explore why they feel young people engage in sex at an early age. The reasons they give most often show what need they are trying to meet. The leaders then help the young people to see that these needs ("to be popular," "to hang onto a boyfriend," etc.) will not necessarily be met by having sexual intercourse. This session also gives young people opportunities to look at the actual social pressures of today's world. For example, the advertistments that use sex to sell products are examined objectively. Leaders help young people understand that what often happens is that people forget about the product but remember the sexual message.

Session II presents information and exercises relating to peer pressure, both in group situations and on a one-to-one basis. Young people are given opportunities to become familiar with common pressure statements and, after responses are modeled for them, they practice responding in their own words. Session III presents information and exercises relating to problem solving. It promotes understanding of the appropriateness of limiting physical expression of affection and, through the development and performance of skits, provides guidance in handling difficult social situations. Session IV provides reinforcement exercises for using new skills.

Summary: The Series on "how to say no" was designed to provide young people with tools to help them bridge the gap between their physical development and their cognitive ability to handle the implications of such development. It was not designed to replace the provision of factual information about human sexuality and family planning. It is our feeling that teens who decide not to have sex get little support and few rewards from agencies and others for their behavior. Programs and support systems are designed for those who have sexual intercourse and/or become pregnant, not for those who don't.

The Postponing Sexual Involvement Series can, at a minimum, strenghten the resolve of young people who have already decided they don't want to become sexually involved, and make they feel supported in their decision. For those who are ambivalent about beginning to have sexual intercourse, it can help them develop attitudes and skills which will assist them in postponing sexual activity. It can also help sexually involved young people. A random sample survey of the Emory-Grady Teen Services clinic population of sexually active girls 16 and under showed, surprisingly, that what they most wanted information on was "how to say no without hurting the other person's feelings". Thus, the curriculum also has the potential for helping these young people communicate more effectively in their current and future relationships.

Chairman **Miller**. Thank you. Dr. Pressman.

STATEMENT OF MAURIE PRESSMAN

Dr. **Pressman**. Mr. Chairman, members of the select committee, I too want to thank you for this privilege of being here and offering testimony.

I want to say that I too want to be a hero by being extemporaneous, but I am afraid I don't have enough courage. I am afraid I will leave something out, so I will make a promise that my presentation will take 10 minutes.

Having said that, I would like to be extemporaneous for a moment. That is——

Chairman **Miller**. Having your cake and eating it too, you know.

Dr. **Pressman**. Right. Frankly, I would like to make my contribution, so I will be addressing the problem of health care in the United States, especially to youth and children, but not only them.

I would like to also suggest that we follow the wisdom of the sage that said it is better to give a fishing pole than a fish, and to try to encourage that principle as we go on, to see programs which will in turn produce for society so they may in turn fund themselves. So much for courage.

The present crisis in burgeoning health care costs provides a background for a new approach for the alleviation of human suffering of medical illness and of America's health.

Our crisis will be addressed by seizing it with two prongs of the tong:

On the one hand, to increase efficiency and thereby reducing health care costs, but, on the other, to alleviate suffering by the promotion of health and wellness and the release of human potential.

This is relevant to all ages, but most particularly to children and youth.

For some time now we have been aware that the application of psychiatric or psychological consultation to the general medical patient reduces the need for overall medical care dramatically. This has been very well described in a series of studies which have been gathered together by Kenneth R. Jones and Thomas R. Vischi.

Their publication in Medical Care, an official journal of the medical care section of the American Public Health Association, provides an excellent review of the literature concerning the impact of alcohol, drug abuse, and mental health treatment on medical care utilization.

This was published in December 1979, and is furnished as an appendix of this presentation, describing the studies which reach back to 1967 and their impact upon the practice of American medicine and, therefore, their impact upon the reduction of health care costs has been negligible.

It is well known that the rate of progression of health care expenses is alarming to the point of bankrupting our economy, our country, and private corporate efforts in the foreseeable future.

The review of the research literature by Jones and Vischi coordinates with clinical observations to the effect that our medical schools focus for the most part upon material and physical phenomena.

Laboratory studies and physical findings and history revolve upon so-called objective data.

The psychological investigation of the individual is minimized as less pure and less scientific. At the same time, we see that human suffering is always a mixture, an alloy of physical organic phenomena and psychological phenomena.

The rapid progression of neurochemical research in the field of psychiatry now brings to bear knowledge about the so-called placebo effect. The placebo, once scorned as a contribution of imagination, is now recognized as a powerful instrument, perhaps producing positive results in 30 to 40 percent of the research population, and mediated by the mobilization of the body's own stores of morphine or endorphins, and related substances.

Expanding research indicates that the psychological effects have everything to do with the management of anxiety and, in fact, that there are abroad in the body, the body's own analogues of valium and librium, the well-known tranquilizers.

Therefore, we are rapidly building a view of the bridges which exist between the powers of the mind and the chemical responses of the body.

All of this coordinates well with the fact that psychological factors have everything to do with the genesis of illness and with the rate of recovery. Unfortunately, our medical body is still trained to eschew the investigation of psychological factors; therefore, if someone comes into the hospital with low back pain, even low back pain which may be predicated upon a visible herniated disc, attention is directed toward stretching the patient, giving him muscle relaxants and to let it go at that. The point I was trying to make is that it is well known that psychological factors participate importantly.

Now, this ignoring of the psychological factor is indeed unfortunate, for it is well recognized by orthopedists that psychological factors contribute even to those proven organic cases of herniated disc.

The patient, once stretched, may recover and then be sent home to the very factors which generated anxiety and the problem in the first place, to trigger the organic event.

This is, indeed, unfortunate, for it is now easy to investigate psychological events and to take care of them with modern and rapid techniques for managing anxiety, family problems, sexual difficulties, and so on.

This brief example, as it pertains to low back pain, can be multiplied many times in terms of the management of hypertension. High blood pressure is a symptom of stress in by far the predominant number of cases, rather than the outgrowth of kidney disturbances, GI disturbances, and many so-called idiopathic disorders.

The result, therefore, is that perhaps a most important determining cause of medical suffering is unrecognized, often the root of the trouble is not eradicated, the patient returns repeatedly to the physician's office, or hospital, wherein the over-established ideal is practiced of investigating the patient with X-rays, CT scans, laboratory studies, and various other physical approaches, while the important contributory agency remains undiscovered.

It is my firm belief, buttressed by such studies as that by Jones and Vischi, that the mandating of brief psychological investigation and when indicated brief psychological treatment will significantly reduce this phenomenon of partial diagnosis and significantly reduce, therefore, the need for repeated expensive laboratory and X-ray studies, as well as repeated expensive hospitalizations.

This approach of mixing psychological diagnosis with medical diagnosis can now be supported and buttressed by the fact that we do have so many new and effective psychochemical and rapid treatment approaches to patients.

So much for the addressing of an issue of reducing health care costs through the application of psychological diagnosis. What about reducing the need for crisis health care through the application of health and wellness principles and the release of human potential?

What about the application of this to the specific issues of child, youth and family services?

It was Freud's great discovery that a huge portion of the mind operates unconsciously—beyond the patient's awareness. Whereas psychoanalysis has proven to be a very expensive and time-consuming treatment, its gift to the medical profession resides in its functioning very much like an X-ray of the mind.

By the application of psychodynamic spectacles, we can, so to speak, look inside a person and see where his potential lies, where his hidden well-springs of desire and interests lie; where his barricades of anxiety and inhibition reside, barricades which prevent the flow of interest.

It is our firm belief that if one can assist a person of any age to find the source of his hidden well-springs of interest and help those springs to flow, that the result will be a free flow of interested activity, a better result in terms of the product, and a smooth-functioning human organism who is so engaged in his pleasureful and productive activities that time becomes a secondary factor.

The basic theme is that if we can discover the base of the hidden potential of the human being and release it, if we can do this by also removing the inhibitions and false anxieties which may prevent him from following his star, we can enable an individual to flow. The benefits will reside not only in increased mental health, but also its corollary, increased physiological health.

Experience with Olympic athletes, "Mind Over Figures," Skating magazine, 1978; "Psychological Techniques for the Advancement of Sports Potential," Coach, Athlete, and the Sports Psychologist, 1979; "Psychological Techniques for the Advancement of Sports Potential," Psychology in Sports: Methods and Applications, 1980; "Psychodynamic Experiences in an Olympic Skating Camp," Sport Psychology: An Analysis of Athlete Behavior, 1980, indicate that it is much easier to work with a well population than with a population which is medically or psychologically at risk. The psychological and psychotherapeutic instruments which, when applied to the neurotic or sicker patient, require a great and repeated push in order to move the patient forward, produce a quite different result in the well and well-motivated person. Such people as the Olympic aspirates would seize the opportunities which were offered with these new techniques and spring forward, as would a spring released from a closed box.

We, therefore, propose a program called "fitness by five," and here I would like to pay tribute to Dr. Marvin Clein, formerly of the University of Denver, who authored and elaborated this idea.

"Fitness by five" is a matter of producing an optimal state in a child by the time he is 5 years old. This rests upon applying the same techniques to the developing child as we apply to the Olympic athlete; namely, to take a biomechanical assessment of his various muscles, bones, joints, and see wherein his weaknesses and strengths lie, and then to create a program to develop that potential to its fullest.

Similarly with the inner physiology, to develop to its optimum the cardiovascular, the respiratory, the neurological apparatus.

Similarly with the psychological apparatus, the child would be evaluated psychologically. His areas of weakness and potential surveyed and a program laid forth which would help him to develop in the best possible way.

This same tripartite formula, biomechanical, exercise, physiological, psychological, would be applied similarly to members of the family, as well as recreational athletes.

Applying this formula to the sport of choice will allow the person to improve his physical and psychological health, becoming better at his chosen recreational athletic activity.

The application of the formula of fitness by five also implies the need for an important educational process.

We thoroughly believe that education and the promulgation of knowledge can be a powerful instrument for good if it is distributed in an atmosphere in which the soil, so to speak, will lap up the liquid of knowledge.

Accordingly, we would propose the promulgation of information to families through not only conventional means, but also floppy discs, inexpensively manufactured and carrying a message of 9 to 10 minutes, sent to the heart of the household, usually the mother, to distribute knowledge gathered by and discussed by the best authorities in the field. We would educate in areas of normal psychological development and pitfalls of psychological health, being in the areas of child rearing, sexual difficulties amongst parents, drug addiction, and many others. This suggestion, of course, does not preclude the use of conventional outlets for the distribution of information, but possibly is a novelty which can spread information of well recognized authorities in a way that will capture the interest of the family for 9 to 10 minutes.

Health fitness centers. As testimony of that, we are on the verge of developing such a center, hopefully in a more—in a rounder way in Ocala, with Mr. Sid Colen. Sid Colen is a developer who is very optimistic, I believe. He is developing a 90,000-person city there. He wanted to name the city "Icare," so people would go around saying they are from Icare. It would take the concept to the well person and apply it to the people to help people assess physiological age, assess areas of strength and weakness and promote those both in the physical and physiological spheres, as well as in terms of education and psychological sphere—to apply this not only to the young, but to people of all ages—following the formula of releasing health and wellness and thus reducing health care costs.

We further believe and suggest that there be screening techniques supplied through special psychological and psychiatric counselors at various schools in much the same way that the schools now have the advantage of speech and hearing evaluations.

There should also be a brief and relevant and effective evaluation of the individual's psychological achievements and certain pitfall syndromes, such as the propensity toward or the presence of learning disabilities.

Using this as a simple and single example, let us state that many learning disabilities are due to a different kind of information processing in the child than is usual in his school community.

The learning disabled child very frequently comes from a family of architects; therefore, instead of using the lateral domination of one side of the brain or the other, he has a bilateral symmetry which in turns allows him to see things three dimensionally. This becomes a hazard when he is put into the usual educational system.

Instead of seeing the difference between a small "b, p, d," he will vision these letters three dimensionally and notice they are all the same; therefore, substitute one for the other, creating an apparent learning disability in our present educational system.

It is easy to see that what has become a disability also represents a considerable latent talent and such a child can go on to become a talented architect.

Thank you.

[Prepared statement of Maurie D. Pressman, M.D., follows:]

PREPARED STATEMENT OF MAURIE D. PRESSMAN, M.D., HORIZON HOSPITAL, CLEARWATER, FLA.

The present crisis in burgeoning health care costs provide a background for a new approach for the alleviation of human suffering of medical illness and of America's health. Our crisis will be addressed by seizing it with two prongs of the tong: On the one hand to increase efficiency, thereby reducing health care costs; but on the other to alleviate suffering by the promotion of health and wellness and the release of human potential. This is relevant to all ages, but most particularly to children and youth.

For some time now we have been aware that the application of psychiatric and psychological consultation to the general medical patient reduces the need for overall medical care dramatically. This has been very well described in a series of studies which have been gathered together by Kenneth R. Jones and Thomas R. Vischi. Their publication in "Medical Care" (an official journal of the medical care section of the American Public Health Association) provides an excellent review of the literature concerning the "Impact of Alcohol, Drug Abuse and Mental Health Treatment on Medical Care Utilization". Though published in 1979 and describing studies which reach back to 1967 with their impact upon the practice of American medicine, their impact upon the reduction of health care costs has been negligible. It is well known that the rate of progression of health care cost is alarming, to the point of bankrupting our economy, our country and private corporate efforts in the foreseeable future.

The review of the research literature by Jones and Vischi coordinates with clinical observations to the effect that our medical schools focus for the most part upon material and physical phenomena. Laboratory studies and physical findings and history revolve upon so called objective data. The psychological investigation of the individual is minimized as less pure and less scientific. At the same time, we see that human suffering is always a mixture, an alloy, of physical organic phenomena and psychological phenomena. The rapid progression of neurochemical research in the field of psychiatry now brings to bear knowledge about the so called placebo effect. The placebo, once scorned as a contribution to imagination, is now recognized as a powerful instrument, perhaps producing positive results in 30–40 percent of the research population, and mediated by the mobilization of the body's own stores of morphine (endorphins) and related substances. Expanding research indicates that the psychological effects have everything to do with the management of anxiety and, in fact, that there are abroad in the body, the body's own analogues of valium and librium, the well-known tranquilizers. Therefore, we are rapidly building a view of the bridges which exist between the powers of the mind and the chemical responses of the body. All of this coordinates well with the fact that psychological factors have everyting to do with the genesis of illness and with the rate of recovery. Unfortunately, our medical body is still trained to eschew the investigation of psychological factors; therefore, if someone comes into the hospital with low back pain, even low back pain which may be predicated upon a visible herniated disc, attention is directed toward stretching the patient, giving him muscle relaxants, and to letting it go at that. This is, indeed, unfortunate for it is well recognized by orthopedists that psychological factors contribute even to those proven organic cases of herniated disc. The patient, once stretched, may recover and then be sent home to the very factors which generated anxiety and the problem in the first place. This is, indeed, unfortunate for it is now easy to investigate psychological events and to take care of them with modern and rapid techniques for managing anxiety, family problems, sexual difficulties, and so on. This brief example, as it pertains to low back pain can be multiplied many times, in terms of the management of hypertension (high blood pressure is a symptom of stress in by far the predominant number of cases), GI disturbances, and many so called idiopathic disorders. The result, therefore, is that perhaps a most important determining cause of medical suffering is unrecognized, often the root of the trouble is not attended, the patient returns repeatedly to the physician's office (or hospital), and to our established ideal of investigating the patient with x-rays, CT scans, laboratory studies, and various physical approaches, while the important contributory agency remains undiscovered.

It is my firm belief (buttessed by such studies as that by Jones and Vischi) that the mandating of brief psychological investigation and when indicated psychological treatment, will significantly reduce this phenomenon of partial diagnosis and significantly reduce, therefore, the need for repeated expensive laboratory and x-ray studies, as well as repeated expensive hospitalizations. This approach of mixing psychological diagnosis with medical diagnosis can now be supported and buttressed by the fact that we do have so many new and effective and rapid treatment approaches to patients. More importantly, these new approaches lead to a change in life style, in turn releasing human potential, both physically and psychologically.

So much for the addressing of an issue of reducing health care costs through the application of psychological diagnosis. Let us address the issue of reducing the need for crisis health care through the application of wellness principles and the release of human potential. Let us address specific issues of Child, Youth and Family Services.

It was Freud's great discovery that the greater portion of the mind operates unconsciously—beyond awareness and voluntary control. Whereas psychoanalysis has proven to be a very expensive and time-consuming treatment, its gift to the medical profession resides in its functioning very much like an x-ray of the mind. By the application of psychodynamic spectacles, we can so to speak, look inside and see where a person's potential lies; where his hidden well-springs of desires and interests lay; where barricades of anxiety and inhibition reside, barricades which prevent the flow of interest. It is our firm belief that if one can assist a person of any age to find his hidden well-springs of interest and help those springs to flow, that the results will be beneficial indeed: a free flow of interested activity, a better result in terms of the product, and a smooth-functioning human being who is so engaged in his pleasureful and productive activities that time becomes a secondary factor. Our basic theme is that if we can discover the base of the hidden potential of the human being and release it, if we can do this by also removing the inhibitions and false anxieties which may prevent him from following his star, we can enable an individual to flow. The benefits will reside not only in increased mental health, but also its corollary increased physiological health.

Experience with olympic athletes indicates that it is much easier to work with a well population than with a population which is medically or psychologically at risk. The psychological and psychotherapeutic instruments which, when applied to the neurotic or sicker patient require a great and repeated push in order to move the patient forward, produce a quite different result in the well and well-motivated person. Such people as the olympic aspirants would seize the opportunities which were offered with these new techniques and spring forward as if released. We, therefore, would propose a pilot program called, "Fitness by Five".[1] "Fitness by Five" is a matter of producing an optimal state in a child by the time he is five years old. This rests upon applying the same techniques to the developing child as we apply to the olympic athlete; namely, to take a biomechanical asssessment of his basic frame (muscles, bones, joints) wherein his weaknesses and strengths lay, and then to create a program to develop that potential to its fullest. Similarly with the inner physiology, to develop to its optimum the cardiovascular, the respiratory, the neurological apparatus. Similarly with the psychological apparatus. The child would be evaluated psychologically. His areas of weakness and potential surveyed and a program laid forth which would help him to develop in the best possible way. This same tripartite formula (biomechanical, exercise physiological, psychological) would be applied similarly to members of the family, as well as recreational athletes.

Applying this formula to the sport of choice will allow the person to improve his physical and psychological health, becoming better at his chosen recreational athletic activity. The application of the formula of "Fitness by Five" also implies the need for an important educational process.

We thoroughly believe that education and the promulgation of knowledge can be a powerful instrument for good. Accordingly, we would propose the promulgation of information to families through not only conventional means, but also novelty methods: For example, flexible phonograph discs (inexpensively manufactured and carrying a message of 9-10 minutes) sent to the heart of the household, the mother, to distribute knowledge gathered by and discussed by the best authorities in the field. We would educate in areas of normal psychological development and pitfalls of psychological health; in the areas of child rearing, sexual difficulties amongst parents, drug addiction, and many others. This, of course, does not preclude the use of conventional outlets for the distribution of information, but possibly is a novelty which can spread information of well recognized authorities in a way that will capture the interest of the family.

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[1] Tribute here is paid to Dr. Marvin Clein, formerly of the University of Denver, who authored and elaborated this idea.

We would propose the development of health fitness centers (with particular attention to child, youth, and family) as part of a living community. We are pursuing a project in conjunction with Mr. Sidney Colen in Ocala (On Top of the World Center). Mr. Colen is developing a 90,000 person community, and has agreed in principle to develop health fitness centers as part of the living complex. Our plan is to perform the tripartite Health-Fitness evaluation upon the constituent members of the community, and offer this as part of their maintenance fee, and then to design and deliver a program for releasing physical and psychological potential. This will allow for regular seminars centers upon health issues, centered upon normal development, the ages of landmark achievement. We will deal with family problems, the scapegoated child, the abused child, sexual problems, the danger of addiction in this modern-day society, and so forth, and so on.

We further believe and suggest that there be screening techniques supplied by special psychological and psychiatric counselors at various schools in much the same manner that schools have the advantage of vision, speech, and hearing evaluations. There should also be a brief and relevant and effective evaluation of the individual's psychological achievements and certain pitfall syndromes, such as the propensity toward or the presence of learning disabilities. Using this as a simple and single example, let us recognize that many learning disabilities are due to a different kind of information processing in the child than is usual in his school community. The learning disabled child frequently comes from a family of architects; therefore, instead of using the lateral domination of one side of the brain or the other, he has a bilateral symmetry which in turn allows him to see things three dimensionally. This becomes a hazard when he is put into the usual educational system. Instead of seeing the difference between a small "b, p, d", he will vision these letters three dimensionally and notice they are all the same; therefore, substitute one for the other creating an apparent learning disability in our present educational system. It is easy to see that what has become a disability also represents a considerable latent talent, and such a child can go on to become a talented architect. This illustrates the fact that if we were to apply useful screening techniques for such a disorder as learning disabilities in the school, we could discover the disorder early, we could apply the correct educational design for such a child, and prevent a great deal of not only learning disability, but also psychological disability inherent in the fact that during his developmental years he has been exposed to a great deal of failure and attendant ridicule. This example can be multiplied.

Many times the drug addiction problem needs to be ferreted out, not by psychologists and psychiatrists alone, but by the specialists working in conjunction with experienced addiction counselors. It is these counselors who have been through it and have been on the scene for a period of time who can sniff out and identify early addiction problems. This is a most important area of effort, not only because of the size of the problem that exists in our country currently, but also because of the fact that the child or youth once seized, begins to specialize in an adaptation which is an excellent adaptation to the drug scene and to the addiction society, but of course a very poor adaptation to the tasks of life at large. During the years of his addiction, he has fallen farther and farther behind in those other skills which will be necessary in order to serve him in the pursuit of a happy and productive life as a useful and respected member of society.

In summary, if we discover the hidden potential of our children, youth and other citizenry, release it and reward it—all society will benefit.

The x-ray instrument of psychological screening—the use of psychology in planning—will add a new and important dimension to the solution of problems and the release of human potential.

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Chairman MILLER. Linda, in your testimony you mention the mayor's task force in New Orleans, which in 1980 estimated that between 5,000 and 8,000 runaway youth pass through the city each year. You are not talking about 5,000 to 8,000 residents? You are talking about those who come to New Orleans?

Ms. IRWIN. Right, but the one thing we are noticing is that that is significantly changing.

It changed very quickly. I don't know what—how dated that is, but when we examined our records in 1981, over 50 percent were residents of New Orleans. Now, what we have no way of assessing is where those youth are from who are out on the streets and never get to us and of that 5,000 to 8,000 they are projecting, it could be they were projecting that large numbers of those are still from out of State.

We do not see those youth any more. We see mostly local youth. I think some of that is because of the shift in the profile. We are not seeing youth who are on the road looking for Utopia. We are seeing youth who are running away from sometimes very life-threatening situations, but at minimum a family in a great deal of crisis.

Chairman MILLER. You use the term "a pushout and throwaway youth." What is your definition?

Ms. IRWIN. Well, a pushout or throwaway is simply somebody who is not running away by choice, but who is sent to the door and told, we would like not to see you back here again.

Chairman MILLER. You are saying 50 percent of the children you see now are in that category?

Ms. IRWIN. Fifty percent of the projected runaways in the mayor's task force were estimated to be throwaways. I would say that probably that is not as high in our residential population. We are seeing right now a high, high number of youth who have been pulled out of their homes by the State because they are in potentially abusive situations.

The frustration for us in that is that even in a highly abusive situation the family bond is so strong sometimes that you will see a youth, and I went through this experience just a few weeks ago, who voluntarily chose to go home, even though he had been severely beaten, and that is a tension with which we live all the time.

Whether, is the family situation workable, because if it is, then we want to reconcile that situation so the youth can return, but we are seeing fewer and fewer of those youth.

Chairman MILLER. Your testimony strongly suggests that not too long ago it was thought these were children who were running away.

You are now suggesting that the population is much more evenly balanced between children who might be running away and children who might be asked to leave or have been pushed out of their homes for whatever reasons.

I assume when you say pushed out, you are talking about an unacceptable living situation.

Ms. **Irwin**. Sometimes it is purely economic reasons. The family will simply say when a young man gets to be 16, "We have enough trouble feeding this many people. Now it is time for you to go."

That may be said to a girl as well. Sometimes the pushing out is simply for economics.

I suppose that we use "push-out" for that population. When we say a throwaway kid, for us we are talking about a young person whose family does not want him, for whatever reason.

Chairman **Miller**. The end of the scenario, though, is that the social services system or somebody inherits a child.

Ms. **Irwin**. Yes.

Chairman **Miller**. Now they are your child as their guardian ad litem. They become wards of the State, so to speak, or private nonprofit charitables or whoever runs this network of services. But they are no longer for all intents and purposes part of that family.

Ms. **Irwin**. Absolutely. Seventy-three percent of the youth that we saw in the last 6 months, between January 1 and June 30, were either already in custody of the Department of Health and Human Resources, or were not allowed by the State to return home because of some abusive situation.

Chairman **Miller**. So the family of the city of New Orleans is growing, if you will, in a formal sense. In your testimony you mention 90,000 dependency referrals where the State is being asked, I assume, to take some action with respect to the situation in which this child finds him or herself in.

You say that approximately 40 percent of those are reported as abuse and neglect cases.

Am I reading your testimony correctly?

Ms. **Hoffenberg**. There were approximately 90,000 referrals for abuse and neglect. About 40 percent are considered valid by the department of health and rehabilitative services. That is, part of that is our suspicion is part of the reason only 40 percent are considered valid is because there are not enough people to go around and handle reports of child abuse.

Our rates in Florida, since the Child Abuse Prevention and Treatment Act spurred this reporting rate, have risen dramatically and continue to rise and rise and rise and rise.

Chairman **Miller**. But again, if I read your testimony correctly, you are talking about 40,000 children who again are involved with the social services system of the State of Florida, and you suspect that one of the main reasons they are there is because of a history of abuse and neglect with respect to their family living situation.

That is a very significant number of children.

Ms. **Hoffenberg**. The thing I wanted to comment about on throwaway children and some of those problems, also abuse and neglect, one of the basic problems I see is that when crisis hits a family, whether it be they can't control an adolescent child, or whether there is an abusive situation in the home, we don't have enough counselors to deal with that family.

It is a lot easier for our social service agencies to just take that child away from the custody of the parents. Our systems sometimes promote parents to not be responsible for their children. Our court systems don't punish parents and say "You must be responsible for your children."

We sometimes make it easy to take children away from parents instead of what I would like to see in Florida, the juvenile court having authority not only over the child—it is like the child is a property right in court when the child has a problem—but over the families, to order the family go to counseling or engage in supportive services.

Chairman MILLER. Some years ago when I was involved in writing Public Law 96–72, one of the most revealing things we learned was that prior to removal of the child from the home, over 80 percent of the families had no other contact with social service agencies. Nobody was coming in to see what services might be provided, like job training, counseling, or some other low-grade intervention which could be tried before taking the child out of the family and putting him into very expensive foster care or institutionalized care.

We learned that even after the child was removed from the family, over 80 percent of the families never heard from the Social Services Department again. That is the reason we required a showing by the court or to the court that these actions have been taken.

But what you are suggesting is that with respect to abused and neglected children who aren't immediate candidates for foster care the same kind of thing is taking place. No one is working with that family unit prior to the point where we absorb the entire cost and responsibility for the children. There really is no system of care or services for abused and neglected family units.

Ms. HOFFENBERG. We have some pilot projects. We have a couple of what are called intensive crisis counseling projects where people intensively work with families. We have a couple of them. A drop in the bucket, in pilot stages.

Highly skilled, trained professionals. I think it is an excellent project.

One of the problems is that you can have that service for 6 weeks. With serious sexual abuse, serious physical abuse, with parents who have lived in a lifetime of violence, been abused as children, we are asking them to turn around their whole lives, say, in a period of 6 weeks. That is nice, but often not realistic.

The same thing with mental health counseling. Very often with seriously sexually abused children, the abuser is asked to go to counseling and is disconnected from the counseling because we can't carry the person in therapy. We don't have the money. We ask the child to go back to the home before the family is rehabilitated.

I believe in keeping families together, but we have to do a lot more.

Chairman MILLER. What struck me about your figures is that they strongly suggest that we are accelerating the pace at which the public body is absorbing these children, and diminishing efforts at what I would call reunification.

In many instances reunification obviously is not going to work. It is not best for the health of the child and family that they get back together. But there appear to be instances where there is certainly a strong possibility that with proper help that family unit can stay together.

Ms. **Hoffenberg**. We are much more aware, not everybody is aware, but Parents United is a great program, but we don't really have a united kind of prosecution effort to really get that thing going.

We might have one pilot project. With all the needs we have in that particular community, plus all the referrals from other communities, that just doesn't handle it. We aren't getting treatment resources and prevention efforts and reunification crisis efforts fast enough into the community to hit this enormous rate that is going on.

Another thing we haven't touched on, we are telling the schools, law enforcement, neighbors, all kinds of people, to report child abuse and neglect, and sometimes they can't even get you on the phone.

People aren't calling back and saying what happened. Sometimes we are just turning that family or that child in need away from the system. So we are kind of defeating ourselves.

Dr. **Pressman**. I just wanted to say, to piggyback what has been suggested, as I hear it, sort of a forced institutionalization of a child, albeit, what is being asked for, as I understand it, is some kind of mandated family therapy on an out-patient basis first so that that may succeed at a much less costly pace, and prevent the separation of the child from the family. That is a model that has worked with kids who have been mandated, remanded, rather, to hospital programs who otherwise wouldn't be treatable, but, because they are forced to be under treatment by law, they are for a period of time.

What is being said, I think, is that a family which may be disinterested may become treatable if the force of the law is behind it, and if there is funding for out-patient treatment for this.

It may be less costly in the future.

As a principle, I would sure like to support that.

Chairman **Miller**. Lindy.

Mrs. **Boggs**. Thank you, Mr. Chairman. Thank all of you so very much.

I am especially pleased, of course, that you came to be with us today, Linda, and I salute the success of Greenhouse. I think all of you have said we have an inter-generational problem. We have to address the problems in that manner. You, of course, testified that what we really need is individual counseling, temporary shelter and family counseling, and to make the family whole again and to put the child back into a workable, livable situation, if that is possible.

Mr. Chairman, I would like to say that much as Miami, San Francisco, New York, and so on, New Orleans does attract runaway children and throwaway children, and we have many of them there. But I think in the last couple of years we are seeing more children coming for services, because of worsening economic conditions, who are children from our own community.

It may be because the reputation of the program has been advanced as well, but I think that all of us are talking about the need for prevention and how much less expensive it is in the long run.

I would like to ask you, Ms. Mitchell, how you went about getting your program funded, because I have a group of young women professors at Loyola University who several years ago wished to institute a program such as the one that you have been able to pull together, and they were unable to get a Federal grant to do so.

I would like to know how you went about getting yours into being.

Ms. MITCHELL. OK. The funds for implementing the program in the State of Georgia is from the Office of Adolescent Pregnancy, which is a Federal grant, and the money we are using to implement the program in Atlanta Public School System is State funding, maternal child health funds through the job's bill money targeted for jobs for the low-income unemployed. Peer leaders to present the program in the schools were hired with these funds.

Field testing and preparation of the curriculum was done through private foundations.

We also have money from the Ford Foundation to implement the program in the Atlanta school system.

Mrs. BOGGS. That is very good grantsmanship. That is a wonderfully cooperative and coordinated effort.

Mr. Jardon, the treatment of the children that you are especially interested in is something that is so severely needed in every State in the Union. Ms. Irwin will tell you that in Louisiana the State was sued by some parents whose children had to be sent to Texas because we didn't have any facilities for them in the State.

I know that you suggested that perhaps some bricks and mortar, a wonderful facility that could provide 40 beds is a marvelous idea. I wrote a little note to myself saying maybe we need a Hill-Burton Act for those kinds of beds for those kinds of patients.

But every State has this problem. Each State has persons such as the two of you devoted to the situation.

Do you have any suggestion other than Federal grants for actual buildings, so that we could acquire the facilities for the children?

Mr. JARDON. The State legislature every now and then approves so-called special legislative projects, also called turkeys by others.

That is part of the problem. That there isn't a bill that will take this up, per se. The State does fundamental health programs. There is a major deinstitutionalization effort on the way for adult and pediatric patients. There has been some consideration of beginning to fund children's programs.

I wonder whether at least one has been funded statewide, so there is some movement afoot.

The problem is that there doesn't seem to be enough. I have been to Tallahassee for the past 2 years just fighting to get a miserly 2-percent increase over previous grants to help offset inflationary cost increases, and so on and so forth.

I have seen the major battles waged by everyone asking for moneys, and I have seen the fear in every State legislator regarding what will happen if they increase taxes in order to meet all of these needs, and the message we get from year to year is that the State can barely meet the operational needs of all of our programs, let alone create new ones, and it is against that background that I am saying here is a need for which I frankly have no solution.

If today I have a request from a judge or a family for family therapy involving a child abuse situation, today I can deliver care. We have created over the years an army of well-trained professionals. We have outpatient facilities; more or less. We may be quite taxed at one point but not so taxed at another. Homes we don't have. We do not have homes. Without homes our children go all kinds of places. I have seen children who are at an age of 16 or 18 not being able to be placed anywhere, I see them on Biscayne Boulevard selling themselves for sexual favors at $5 a trick and that I think is a total disgrace.

Again, the problem is not often in the amount of money needed, but in what you call it. The Federal grant programs rule under title 45, part 74 of the total Federal regulations, they don't allow for construction moneys. In Dade County I can tell you, we get $5 million for mental health programs. Not $1 is for construction, for one brick, and so we have to deal with that kind of a system that has been created over the years.

That is where the frustration lies.

Mrs. BOGGS. Thank you.

Ms. IRWIN. Excuse me. One of the reasons why I suggested that it seems like when we talk about human service needs we tend to focus over at DH&S, I think somewhere if there were true tax incentives to the corporate community to make contributions, either to public or private need, then we could go a long way. Because we have the same situation in Louisiana, where operating funds requests will be received, but for capital outlay the message is, go out to the corporate community and solicit those funds.

Until we see incentives in the private sector, true incentives to give, we are caught in a catch-22. I really think that is where some of the information that is coming to this committee runs across a lot of the Federal role in how those other structures are set up.

Mrs. BOGGS. We tried our best to get buildings whenever the opportunity seemed to exist. A naval hospital facility needed to be taken over by private enterprise; we tried to get it to the young children with mental illness problems, mental retardation problems. Then when the public health service hospital was closed, the State tried to step in and get some priority acquisition there.

It is so frustrating. That was why I asked if you had some good suggestions.

Doctor, we were so pleased that you took your precious time to come and be with us and to give us so much excellent information and instruction.

I really wonder if you could tell us in the cost of health care, if you think some of the ideas that you have could be incorporated into schools of family health and how we can encourage the medical schools to make certain that the schools of family health are given as high priority as surgical units and so on?

Dr. PRESSMAN. I think we are on the edge of having this happen, by the way. We were not that interested in old people until medicare came along and then there was a great interest in treating old people. Many good things occurred as a result of that. Medicare is having its own problems now, but it has been a marvelous program and has really elicited an interest in the treatment of a segment of the population.

Similarly, if we could, on a pilot basis, and maybe independent industry would be interested in doing this because we can demonstrate to independent industry the effectiveness that these research studies show, the effectiveness in terms of reducing their overwhelming health care costs, so that if one mandates, for instance, one or two psychological examinations, or brief psychotherapy, six sessions, if necessary, and sees what happens over the course of a year, you can be sure that self-insured corporations will then continue to mandate it and the practice of medicine and psychological art will follow.

As far as the Government is concerned, I propose that similarly it could look into making this part of an evaluation of a certain medical segment of the population. Do a pilot study for the treatment of hypertension which is a very destructive disease and very responsive to self-help, frankly.

Certain techniques that we have, with biofeedback, so one could therefore mandate a pilot program, do some studies as to what this does in terms of overall health care costs for a population.

I think funding through insurance will follow and I think the practice will follow. Similarly with many wellness aspects of medical treatment.

Chairman MILLER. Mr. Bliley.

Mr. BLILEY. Thank you, Mr. Chairman. I want to thank the panel again for sharing your information with us and pointing out the many gaps in our service delivery system that we have today, hopefully giving us some direction as to where we might make recommendations to go.

Ms. Mitchell, why do you suppose so few programs have chosen to follow the kind of model that you have developed at Grady Memorial Clinic?

Ms. MITCHELL. Well, I don't know. This is a new approach that we have recently taken and I think at one time we had looked at family planning as a solution to teenage pregnancy. We provide family planning services to all these young people who engage in sex. Then I think we looked at sex education, but I think one of the things experience has taught us over the years is, when you are dealing with very young people, and our target population is 16 and under, it's not just looking only at adolescent pregnancy, but the decreased fertility in these young people as they grow into their early twenties and wish to have children, the effects of sexually transmitted disease, the emotional effects that early sexual involvement has on them, it just came very clear to us that for whatever needs young people are having sex, that there has to be better ways to meet those needs other than through sexual intercourse because the long-range impact on their lives is just too great for them to try to meet these needs through sex.

Mr. BLILEY. Did I understand you to say that your program is now, or is about to be offered throughout the State in the various school districts?

Ms. **Mitchell**. Yes; we have received money from the office of adolescent pregnancy to implement this program throughout the State.

Mr. **Bliley**. Do you have any estimate of how long it will be before you have statistical data to show what effect this program might be having?

Ms. **Mitchell**. It is going to be 3 to 4 years.

Mr. **Bliley**. Three to four years.

Ms. **Mitchell**. Yes.

Mr. **Bliley**. Thank you, Mr. Chairman.

Chairman **Miller**. Is there money in the grants for doing follow-up studies with the populations that will go through the program?

Ms. **Mitchell**. There is a year's research money, evaluation.

Chairman **Miller**. The only research you have done to date is on the acceptability question, on which approach to take?

Ms. **Mitchell**. The field testing is the only research we have done to date. We just finished the field testing of this curriculum in early spring. We have not finished the followup evaluation even on the field test which is to be done, to see what impact the series actually had on the kids' behavior and see if they——

Chairman **Miller**. So there is a followup study that will be done?

Ms. **Mitchell**. To the field testing.

Chairman **Miller**. Good.

Ms. **Mitchell**. So that initial field test evaluation will be available in a year.

Chairman **Miller**. Thank you.

Mrs. **Boggs**. Mr. Chairman.

One thing, Ms. Hoffenberg, I am so glad the young people have you as their advocate.

Ms. **Hoffenberg**. There are 1,500 volunteers.

Mrs. **Boggs**. I know that. What I was wondering, do you have any sort of outreach to the young women in law school to encourage them to be helpful in the program?

Ms. **Hoffenberg**. To become involved in the program? Not only young women, but young men, old women, anybody. We are consistently looking for people. We not only recruit citizens, we recruit attorneys to assist as a team. We continue to look for equipment and other things.

We are very pleased with the support of the system.

Mrs. **Boggs**. It is like the doctors, you know. There is sometimes more money in other fields. I hope the attorneys would feel a special obligation to take care of the problems, legal problems of young people.

Thank you.

Chairman **Miller**. Mr. Lehman.

Mr. **Lehman**. Yes. I just want to let the members of the committee know how much I appreciate them coming to Miami to participate in these hearings, Chairman Miller, "Vice President" Boggs, and Mr. Bliley from Richmond. It is an honor to have you down here in the community.

I would like to ask Mario about this money for the buildings. Is the problem that nobody wants the building in their neighborhood anyhow?

You have a double bind. All those drug addicts and sex maniacs running around loose.

Chairman **Miller**. That is it, Mario. You will never get a building now.

Mr. **Jardon**. We will build them at Hialeah though.

Mr. **Lehman**. One of the reasons we are unique is because we have absorbed 120,000 refugees in a very short period of time. It is an area where many of these refugees are located.

As we know, some of these refugees are not exactly reunification family people. What, off the top of your head, what impact has the so-called refugee had in dealing with the psychological or other problems you have in your role out there? How are we dealing as a community with the impact of the social misfits that were sent, rather than reunited with their families?

You can take the fifth if you want to.

Mr. **Jardon**. No, I would like Ana also to respond to this, but originally we estimated that we would be seeing 10 percent of all the refugees that arrived at one point or another. That came about.

I remember in the very first initial phase when the shelters were being established and they came before FEMA, before FEMA took over, we had a 340-man building—we were seeing no less than 10 percent. We were seeing hundreds of them because of the depression, doubt, all kinds of anxiety, all kinds of symptoms.

In the year after that, we estimated that we would be seeing about 2 percent of them and that 1 percent really would require hospitalization or placement in a facility. These predictions turned out to be true. We had about 25,000 estimated entrants settle in the area of Hialeah. That year we saw 500 of them and 250 or thereabouts were placed, were hospitalized or placed in a residential facility.

Having had the benefit of working with them for about 4 years, I can make the following statement: We have closed more cases than we ever anticipated. It is amazing. On the other hand, those that have remained are very, very sick. The most likely person to be rehospitalized in our caseload is a young entrant, male.

By the way, 83 percent of them came by themselves, having no family attachments whatsoever. That makes it extremely difficult to rehabilitate anyone. I would like Ana also to talk about the Honor Co. adolescents that she has been working with.

Dr. **Rivas-Vazquez**. We had in the area 119 in the company which we identified and tried to resettle. Some of the programs that I mentioned before were programs that were here, working with them. Originally they were 3 percent severe emotional problems. Now, many of the crimes committed were committed by these children.

As of now it has shifted tremendously and some of the children that really were—not had the experience of a relationship, have actually improved tremendously. What we are seeing now is a slightly different variation. They are more or less sort of a culture rating to the community.

Now, interestingly enough, what we are seeing is an awful lot of children from families that came, it is almost like there were cases we are seeing already, now the problems to adapt to the community are emerging. So we are seeing a slightly different pathology in terms of the entrants.

Mr. LEHMAN. It is not the exact aftershock you anticipated?

Dr. RIVAS-VAZQUEZ. Not exactly; no.

Mr. JARDON. There are signs. For instance, I believe about 250 entrants are seen by Dade County courts every month. That makes it about 3,000 per year. What happens is that a lot of them are quite anti-social and they do not necessarily wish to be seen in our facilities. We presently have in residence no less than 40 of them, which is a significant number. We keep hospitalizing.

Mr. LEHMAN. I just want to, as much as possible, get on the Federal record the fact of the burden this community has had to contend with that was different from other communities, which is on top of other problems we have had in this community.

So, hopefully, we can get some Federal help and I will try to work with the committee in that line.

I would just like to ask Dr. Pressman, the young people that come into your facility, they are paid for by the State for a while under such a program, right?

Dr. PRESSMAN. Yes.

Mr. LEHMAN. This is a private hospital?

Dr. PRESSMAN. Private hospital, but we have a contract with the State.

Mr. LEHMAN. They can stay there if they are mentally disturbed, psychologically sick; they can stay a certain period of time, then State funds are cut off?

Dr. PRESSMAN. Yes; for acute care they are. There are the backup of State institutions.

Mr. LEHMAN. I am trying to figure out, they need hospitalization; they are not able to pay for the hospitalization. The 16-year-old, mixed-up kid, the State money runs out, the family doesn't know what to do with them, what happens to the child?

Dr. PRESSMAN. We have done a variety of things in conjunction with the State. The State has assumed generously a terrific burden. The amount of hospitalization which is allowed by the funding is really a matter of establishing the quelling of crisis and trying to establish some links with outside agencies such as the community mental health centers.

In all truth, let's say in the Tampa or Clearwater area where we have a hospital, the community mental health centers are overwhelmed and we have established just privately some intermediate clinics to take care of these people until they can have their next appointment; the point being, in summary, that the community mental health system has done a great service. It is not able to meet its obligations.

The private institutions, such as ours, coordinate with the State-funded institutions and do the best they can, but the whole thing is really quite inadequate to the needs.

Mr. LEHMAN. It is all wired together with spit and glue.

Dr. PRESSMAN. It is. It could be wired together better.

Mr. LEHMAN. If you are a private institution, you can't afford to keep them when the State is no longer paying for them.

Dr. PRESSMAN. That is right.

Mr. LEHMAN. Where you can put these people after—there is really no catch-all operation. How many days can you hold them with State money?

Dr. PRESSMAN. Fifteen on the average.

Mr. LEHMAN. After that you would have to keep them for free or put them out to some institution or family or somewhere else that really is not able to serve them?

Dr. PRESSMAN. We need more links. The State does send in its social service facilities in order to enable continuity of care. We do have the outpatient mental health centers as well as other agencies, but the whole thing is really not up to meeting the problem.

Obviously we need more attention to their suffering.

Mr. LEHMAN. So we have people out of the institutions before they are ready to hit the streets?

Dr. RIVAS-VAZQUEZ. I would like to add that these are the cases we see and the case review committee, and the ones Mario was talking about, that we have to send out of State because we don't have any facilities in the State to actually put the children. That is what happens to many of those cases.

I sit on the case work committee every 2 weeks.

Mr. LEHMAN. The same people go back and forth between Mario and Dr. Pressman.

Mr. JARDON. May I point out something?

Again I think in the case of the Memorial Hospital, we are dealing with an institution that is extremely sensitive to the needs of the poor and is willing to work with community mental health centers, and state agencies, but let me illustrate what happens generally and how the same laws we write in the books are really not doing their jobs.

Mr. LEHMAN. I am talking about children mainly.

Mr. JARDON. With children. I have recently a referral from a mother who works, has insurance, and the child had severe emotional problems, went to a local hospital. For over a year. That is more than a year in the hospital. Insurance benefits ran out.

Now the mother has no place to place that child. The ironic thing is that the legislation such as medicaid would not pay for certain services such as residential. Yet it would pay for that hospital for over a year. Here is where we have some things that, with only minor tuning, the moneys could go a longer way.

Mr. LEHMAN. It just needs to be organized. Thank you very much for being here today.

Chairman MILLER. On behalf of the committee, I want to thank you and to thank Congressman Lehman for hosting this select committee hearing in Miami.

The select committee stands adjourned.

[Whereupon, at 3:33 p.m., the committee was adjourned.]

PREPARED STATEMENT OF HUGH S. GLICKSTEIN, JUDGE, DISTRICT COURT OF APPEAL, STATE OF FLORIDA

Members of the Committee, I am grateful for the opportunity to provide you with information for your record. As organizer and chairman of the Florida Bar's Special Committee for the Needs of Children, I submit this statement for the record to tell you what the children of this nation would tell you personally; namely, that your leadership—your personal, individual commitments are desperately needed now—to provide the resources to respond to America's greatest internal needs—those of its children.

I want to read you part of the statement of purpose of the committee that I chair: Our first purpose is as follows:

To raise the consciousness and support of the leaders and citizens of Florida in order to achieve the commitment of resources—tangible and intangible—to the needs of children based on the following premise;

It would be society's greatest reward—tangibly and otherwise—were the future adult inhabitants of this state able to look back to the 1980's and reflect how their predecessors finally came to recognize the priority to be given the well being of children. Such future citizens would undoubtedly be the beneficiaries from (1) our present awareness that children are our most precious gift and entitled to enjoy the happiness which only adults can provide; and that they are our only priceless commodity—the key to the well-being of society; and (2) our recognition that without prioritizing the physical, emotional and educational needs of children, all the efforts to eliminate crime, poverty and ignorance are only kneejerk, bandaid solutions which cure none of society's basic ills.

Attached to this statement is an appendix which illustrates that our committee is "hands on" or "task oriented" as you must be. It functions through several subcommittees who are in existence to do something, not just discuss it. Such action—mindedness is consistent with the history of the Florida Bar. As you can see from the exhibits which are part of the appendix, we have enlisted the support of leaders of the American Bar Association so that body, already committed to responding to certain needs of children, will expand its areas of focus not previously addressed.

I urge you to encourage the Senate to transform its existing informal caucus to a standing committee which will address, like yourselves, the needs of children by a permanent, staffed organization.

In closing, I reiterate my initial premise; namely, that children are not able to speak for themselves. Only adults can provide them roots and wings. With your caring, attention and ongoing commitment each child can someday have the opportunity he and she deserve.

APPENDIX TO STATEMENT

The purpose of this article is to acquaint you with the above, newly formed special committee; to tell you a little bit about how it came to be; and, most important, to let you know what it hopes to accomplish with your assistance.

First, as to its origin, in the summer of 1982, I developed (a) the growing concern that basic societal problems could only be attacked at their roots by focusing upon children and (b) the belief that The Florida Bar should direct its energies in that direction. As the father of three children, a practicing lawyer for over twenty years, a prosecutor of capital cases, and a trial and apellate judge, I had experienced a number of incidents that convinced me that every child had to be given as much opportunity in life as was necessary to grow into a happy, productive individual. Judges Harry Lee Anstead and Daniel T. K. Hurley of our court encouraged my idea of the formation of a children's committee by The Florida Bar, as did Judge William E. Gladstone, a friend of over 30 years and leader in the juvenile justice system. In November 1982, the Program Evaluation Committee of the Bar approved the concept; and the Board of Governors then approved the committee's formation in early 1983.

Before the committee's first organizational meeting, four projects were undertaken by a handful of organizing members. First, at Robert E. Livingston, Esq.'s suggestion, the Board of Governors invited Marlene Josefsberg of Miami to appear at its regular meeting to discuss drug and alcohol abuse among children. From that appearance, Marlene and the Board wives put together a program at the Bar's Annual Convention, which hopefully will regularly be presented. Second, following Judge Gladstone's appearance before the Board of Governors, we undertook to support the Governor's Constituency for Children, which had been conceived by Judge Gladstone. This is a pilot program in nine Florida counties predicated upon bringing volunteers and professionals together in recognizing and fulfilling children's needs in each community. Third, Ellen Hoffenberg, Esq. put together a presentation at the child abuse program held at the Capitol in April. Finally, all legislators, county bar associations and major newspaper editors were informed by letter of the formation of the committee.

On May 4, 1983, the organizational meeting produced the following statement of purpose of the committee:

(1) To raise the consciousness and support of the leaders and citizens of Florida in order to achieve the commitment of resources—tangible and intangible—to the needs of children based on the following premise:

It would be society's greatest reward—tangibly and otherwise—were the future adult inhabitants of this state able to look back to the 1980's and reflect how their predecessors finally came to recognize the priority to be given the well being of children. Such future citizens would undoubtedly be the beneficiaries from (1) our present awareness that children are our most precious gift and entitled to enjoy the happiness which only adults can provide; and that they are our only priceless commodity—the key to the well-being of society; and (2) our recognition that without prioritizing the physical, emotional and educational needs of children, all the efforts to eliminate crime, poverty and ignorance are only kneejerk, bandaid solutions which cure none of society's basic ills.

(2) To effect a response to those needs by attention to the following and other problems and by means of the following and other vehicles and programs:

A. Adoptive services;
B. Communications;
C. Constituency for Children;
D. Corporate support;
E. Delivery of legal services;
F. Delinquent and dependent children, including those that are abused, abandoned, neglected, and runaways, truants and ungovernables;
G. Deinstitutionalization;
H. Drug and alcohol abuse;
I. Education and day care;
J. Family law and preservation;
K. Fiscal and programmatic accountability;
L. Guardians-ad-litem;
M. Information and resources;
N. Juvenile Justice;
O. Lay and professional voluntary services;
P. Legislation;
Q. Local bar, medical and other professional associations;
R. Medical services;
S. Mental health;
T. Missing and molested children;
U. Out-of-state activity;
V. Poverty and hunger;
W. Prosecutor and public defender associations; and
X. Scouting and family forum.

The members voted also to create the following ten sub-committees to achieve the committee's aspirations:

Committee and statement of purpose:

(1) Children and the law: Adoptive services;

(2) Constituency for children: Constituency for children; Lay and professional voluntary services.

(3) Drug and alcohol abuse: Drug and alcohol abuse.

(4) Education: Education.

(5) Family and community life: Family law and preservation.

(6) Health and welfare: Deinstitutionalization; Medical services; Mental health; poverty and hunger.

(7) Information communications and resources: Communications, information and resources.

(8) Juvenile justice: Delinquent and dependent children, including those that are abused, abandoned, and neglected as well as runaways, truants and ungovernables.

(9) Missing and molested children.

(10) Voluntary services: Corporate support; guardians-ad-litem; lay and professional voluntary services; local medical and other professional associations; out-of-state activity; prosecutor and public defender associations.

The committee met again at the Annual Convention in June; selected chairpersons for each subcommittee; adopted requirements for recommending active support or opposition by the Bar to legislation, and agreed to appear before (1) all county bar associations to encourage each of them to create committees for the needs of children; and (2) newspaper editors and county school boards throughout the state to discuss the committee's purposes.

Since its organization, the committee has achieved the following:

(1) Obtained a commitment from Nova Law Center to dedicate the winter issue of its law review to the needs of children and prepared the articles for that issue.

(2) Contributed substantial effort throughout the state in the organizational efforts of communities to combat drug and alcohol abuse by involvement in the Chemical People.

(3) Obtained the dynamic support of the Chairman of the Family Law Section of the American Bar Association for (a) the Resolution initiated by the committee for presentation to the American Bar Association and (b) the attention to the needs of children by the Family Law Section.

(4) Effected the activation of a children's committee by the Family Law Section of the Florida Bar.

(5) Effected the creation of local children's committees by various bar associations in Florida.

(6) Substantially assisted in obtaining legislative funding for the Governor's Constituency for Children.

(7) Initiated, through its Health and Welfare Sub-Committee, the task of creating a computerized information bank for Florida which will contain basic information on both public and private resources and services statewide which are available to meet the needs of children and families.

(8) Adopted and circulated Statements of Purpose for each of its Sub-Committees.

(9) Undertook, through its Education sub-committee, the study of the need for character education in the public schools of Florida to the end of effecting character education for children and role models for teachers.

(10) Undertook the study of needed legislation, affecting children, in order to promulgate a legislative program by the end of the year.

COLUMBIA, S.C., *October 31, 1983.*

Hon. GEORGE MILLER,
House of Representatives, Chairman, Select Committee on Children, Youth, and Families, Washington, D.C.

DEAR MR. MILLER: I am honored to respond to your invitation to submit written testimony for the record of the Select Committee on Children, Youth, and Families. I am sorry that I was not able to appear before the committee in Miami. Our voluntary organizations do not have the resources to support travel outside the state. I am pleased to know that you have solicited comments from groups that are high on commitment and energy and low on funds.

As a long-time advocate for children and families in South Carolina, I am excited about the potential impact the Select Committee can have on the quality of life for all families. My experience has been primarily in the private non-profit human services sector. I was the founding Executive Director of the Council on Child Abuse and Neglect, Inc., an agency serving four counties in South Carolina with prevention, treatment, education, and advocacy programs. I was also the founding Executive Director of SISTERCARE, INC., an agency serving abused women and their dependent children. Last year I was privileged to be a member of the consulting team which designed a continuum of care for emotionally disturbed children in South Carolina. Governor Richard Riley recently appointed me to serve as one of his representatives to the Joint Legislative Committee on Children of the South Carolina General Assembly. My work in South Carolina for the past ten years has exposed me to a range of critical issues confronting families and children.

The following testimony is drawn from my experience. The comments are my own professsional opinion and are not intended to be the representation of any one of the organizations with which I am affiliated. Of course, I cannot possibly summarize all the critical needs within this context. I must instead focus on a number of priority issues.

Thank you for the opportunity to provide this information. I do hope the Select Committee will continue to solicit input from the voluntary human services sector as your study progresses. I wish you well as you proceed with your challenging task.

Sincerely,

ARLENE BOWERS ANDREWS.

PREPARED STATEMENT OF ARLENE BOWERS ANDREWS, COLUMBIA, S.C.

Attention must be drawn to the shocking level of violence behind the closed doors of American homes. The violence, which is committed by family members upon one another, takes many forms: physical assault may include such actions as slaps, beating with objects, using lethal weapons; neglect may include withholding food or medical care; psychological abuse may include such acts as locking in a closet, threats of harm, and intimidating acts which cause family and friends to withdraw social support; sexual assault includes a range of physical assaults as well as forced participation in pornography or other exploitative activities. The underlying causes of these various forms of violence are many; further study is needed to understand them.

However, the effects of the violence are all too obvious. Those familiy members who suffer the most harm are children, women, elderly, and/or handicapped. Following are a few facts:

Twenty five percent of all married couples report having used physical force upon one another. Researchers estimate the actual rate is underreported, and may be as high as 50 percent. Several studies indicate women are the injured party in 95 percent of domestic abuse cases; when psychological harm is included, they account for 99 percent of the victims. Children and elderly family members are at risk of harm in families where spouses use violence.

Ninety eight percent of all parents use physical punishment with their children. Many use the punishment at excessive levels, resulting in abuse to between two and six million children each year.

It is predicted that 30 percent to 40 percent of all children will be sexually assaulted before age 18.

Fourteen percent of all wives are sexually assaulted by their partners, most under threat of violence. In 25 percent of couples studied, the assaulting partner committed the assault because he wanted to practice an act he had observed in the pornographic media.

Perhaps as many as 500,000 elderly persons are abused each year by a family member.

Often the victim of family violence is further victimized by the service system which is supposed to offer help. Many helping systems are involved: social, medical, legal, law enforcement, religious, economic. Yet intervention programs for family problems are hampered by ambiguous and unclear policies. Tension exists between norms respecting the rights of family visits and those respecting the individual rights of family members. Rights of the victim are balanced with rights of the accused. An attitude of tolerance and reluctant intervention pervades many of the systems which could be responsive after family violence occurs. These attitudes affect prevention efforts as well; few programs exist to train parents, spouses, and children in non-violent problem solving tactics or to promote positive support to reduce family stress. The prevention programs that do exist are primarily in the private sector with extremely limited funds. Assertive public policy support for prevention and intervention efforts is needed.

One result of this tolerant atmosphere is that a system of "frontier justice" occasionally prevails. The victimized wife or child, frustrated by attempts to seek help, strikes back at the assailant with lethal means. Violence breeds violence. Or permanent harm to the victim occurs, causing this problem to be passed on from generation to generation: note the numbers of emotionally disturbed and aggressive adolescents who were early victims; the chronically depressed, suicidal victim of wife-battering; the self-abusive victim who turns to alcohol, drugs, prostitution; the well-intentioned adult who is unable to maintain a stable family life or practice healthy parenting skills. The cycle of violence is perpetuated, from generation to generation.

I urge the Select Committee on Children, Youth, and Families to solicit testimony from victims of family violence. The degree of terrorism in the homes of our country is truly frightening.

An investigation of the adequacy of helping systems is also needed. I suspect you will find a high level of inadequacy. Child protection systems are predominantly state systems with federal social services block grant support. Child protection programs have developed an adequate ability to identify child abuse and neglect cases, but are appallingly deficient in being able to offer treatment or safer alternatives than what existed prior to case identification. Prevention of child abuse has been left primarily to the private sector. Adult protection systems, aimed at the elderly and handicapped adult, are like the other state programs, generally inadequate. Services to victims of spousal violence have arisen primarily in the voluntary sector, using courageous self-help models. Many states have provided partial funding, but federal participation has been sparse.

Most Americans are committed to the ideology that our homes are havens of peace and security. In order for this ideology to become reality, we must have clear national policy to maintain that hurting a family member is wrong and that it is in the national interest to support services that will help victims of family violence, promote healthy family relationships, and reduce stressors that exacerbate family difficulties.

Other priortiy issues which create significant stress for many American families are:

(1) Subsistence: One of every six families in South Carolina lives below the poverty level. Many of these families are headed by women who encounter substantial difficulty in finding stable jobs that will provide enough income to support a family. Equal opportunity, equal pay, and generally equal rights for women will increase the quality of life for families. Jobs and job training must continue to be available to men as well as women.

Subsidized child care, housing, medical care, and food supplies at adequate levels are essential to help families help themselves out of the proverty cycle. Recent budget cuts for economic assistance and human services have had a serious impact on South Carolinians.

(2) Education: The status of education in South Carolina is critical, as our current governor has assertively recognized. Our state has one of the highest illiteracy rates in the country; our students typically are among the lowest achievers on national standardized performance tests. We have a disproportionate number of disadvantaged learners, yet fewer resources to apply to our educational system. Federal funds and technical assistance are essential for the well being of our educational programs.

Adult education is also a priority issue, as our economic base is gradually changing from manufacturing to technological and research industries. Many of our indigenous residents cannot compete for new jobs requiring higher skills, particularly as workers with higher skills move into the state from other areas.

(3) Health/mental health: I would like to emphasize the issues brought to your attention by Dr. Joanne Fraser, who has also submitted written testimony to your committee. Parents need special health care as well as social support during the first year of a child's life. The quality of parent-child interaction during those first formative months is a key step to the prevention of subsequent child abuse and/or neglect.

Families live with considerable stress associated with many factors: economic, social, environmental. Attention must be focused on one factor which has only recently begun to receive emphasis: the manufacture of nuclear weapons and other actions in preparation for nuclear war are having a serious impact on children and adults. Psychological studies have demonstrated that many children feel despair, alienation, fear, and distrust of adults because of concern over the likelihood of nuclear war. Commitment to future family life, including procreation, is questioned by many children. The impact of national defense policy on our domestic life needs to be evaluated.

What can be done about helping families? I can share with you a glimpse of what is being done in South Carolina. I regret that only a few projects can be shared. These are intended to represent private sector and state initiatives.

Sistercare, Inc., is a private non-profit agency serving abused women and their children in the Midlands area of South Carolina, with a population of 600,000. A range of services are provided around the clock, including crisis telephone, shelter, counseling, children's program, support groups, community education, and a special prison program for women inmates who are former victims of abuse. These services are provided by only six full and three part-time employees, thanks to over sixty active volunteers who give time and hundreds of community citizens who give support in the forms of material donations, funds, and occasional services. Maintaining Sistercare is a constant effort, since need for service is much higher than the capacity to respond, and secure funding from year to year can never be assured.

The Midlands area, however, is more fortunate than many neighboring areas of South Carolina, which have no services for domestic violence victims. Start-up funds, particularly for rural programs, are sorely needed.

Welcome Baby and Parent Friends are programs of the Council on Child Abuse and Neglect, Inc. Their goal is to provide caring, sharing, and support for new mothers through hospital and home visits soon after birth. They rely entirely on volunteers, with part-time staff support for coordination and training. The Welcome Baby program has been adopted throughout many parts of South Carolina and has been adapted by the U.S. Department of the Navy for its hospitals worldwide.

A pilot program for a similar service in the Pee Dee region of South Carolina, using paid paraprofessionals as "resource mothers" for young single mothers, has demonstrated that the health and competence of teenaged mothers and their babies are improved by such help (Heins, Wandersman, & Unger).

The S.C. Department of Social Services is training AFDC mothers to work as homemaker-home health aids for the elderly. The quality of life for both families—that of the elderly and the homemaker—stand to benefit from this program.

This year the South Carolina General Assembly will consider proposed legislation to establish a Children's Trust Funds, which would provide resources to private nonprofit organizations so that innovative children's programs can be initiated.

A pilot continuum of care for emotionally disturbed children will be established this year, thanks to the initiative of the South Carolina Governor's Office and the state Developmental Disabilities Council. The Continuum is governed by a unique interagency policy council. Its goal is to provide adequate treatment of children whose behavior is such that conventional mental health, education, and youth service agencies cannot fit them into their programs.

Working with many of these creative and cost-effective programs is often like being the fiddler on the roof. One never knows when the support required to maintain the program may have to go. Dedicated volunteers work to the point of exhaustion or until their own family lives begin to suffer. The problem is so vast; but when children or threat to life is involved, prompt response is critical.

You can help. Many of the issues brought to your attention by this testimony and others require further study; all need stable national policy action. These issues are certainly not an exhaustive list; rather, they are a select list of the more critical factors affecting children and families as my experience indicates. I urge you to study and take action on the following issues;

Methods to stimulate family support initiatives by the private nonprofit human services sector;

Legislation to stimulate intervention into and prevention of domestic violence;

Methods to stimulate state and local action on behalf or crime victims, particularly victim compensation programs;

Evaluation of the adequacy of child protective services provided through the social services block grant;

Assertive methods to reduce the production and distribution of all pornographic materials (many concerned persons seem to avoid this issue because censorship is an undesirable intervention; surely there are other creative ways to act on this issue);

Policies and programs to stimulate health parent-child bonding;

Methods to support single-headed families; particularly, support for the Equal Rights Amendment;

Policies and programs to create jobs and job training;

Maintenance of the U.S. Department of Education and its programs; particularly those directed at the disadvantaged and adult populations; and

Examination of the effect of nuclear defense policy on family quality of life, including psychological, social, and economic impacts.

PREPARED STATEMENT OF ROBERT S. STEMPFEL, JR., M.D., UNIVERSITY OF MIAMI, PROFESSOR AND VICE CHAIRMAN, DEPARTMENT OF PEDIATRICS AND DIRECTOR, MAILMAN CENTER FOR CHILD DEVELOPMENT

This year Congress has seen fit to take a timely and extremely important step toward the recognition of the needs of children and parents in creating the Select Committee on Children, Youth and Families of the U.S. House of Representatives. It is particularly encouraging that the Committee has chosen to emphasize Prevention as one of its principal concerns.

The following is a prevention system model presented for the Committee's consideration. It is being developed under the cosponsorship of the University of Miami and the State of Florida in a federally inspired facility.

The University of Miami Mailman Center for Child Development was created in 1971 as one of twenty University Affiliated Facilities (UAF's) through federal legislation enacted in the mid-1960's. This entailed a federal construction grant against which matching funds were provided by the Mailman Foundation and by the Joseph P. Kennedy, Jr. Foundation and a multidisciplinary training grant administered through DHEW-Maternal and Child Health. Over the past decade the Center's activities have been sustained by support from over thirty different federal, state and private sources.

The original enabling legislation described UAF's as centers of excellence to be established for the purpose of increasing health manpower in the field of mental retardation through graduate interdisciplinary training programs. Over the ensuing years the health care target was modified to include a broader range of handicapping conditions and the Center was allowed to place more appropriate emphasis on prevention.

Over the past four years, federal sponsorship of the UAF training program has been progressively reduced to but one-third the 1980 support-level. However, because of the Center's commitment to community health service and training priorities, the State of Florida elected to preserve the program, and in its 1983 Legislative Session, appropriated funds to offset federal losses.

The mission of the Mailman Center is the preparation of professionals for leadership roles in health management for the developmentally disabled. Toward this goal, the Center has developed graduate training programs of the highest quality utilizing an exemplary service system under the supervision of academically competitive professionals. The Center maintains a full-time faculty of forty-five in the disciplines of pediatrics, psychology, nursing, social work, speech and hearing, nutrition and special education who conduct programs that express a balance of training, service and research in the area of prevention.

The most direct means of eliminating handicapping conditions is simply to prevent their occurrence. Such "primary" prevention requires a more rapid elevation of socioeconomic secular trends, the abrogation of unfavorable environmental influences, the universal application of sound family planning and prenatal care and the efficient utilization of diagnostic technology to identify and eliminate undesirable pregnancy. Assuming that all of these objectives are not immediately attainable, the bulk of our prevention resources must be applied to the "secondary" prevention of handicapping consequences of conditions we have been unable to avoid.

By and large, these efforts have been influential in curtailing unfavorable outcomes and in some instances have proven to be efficient as well as cost-effective (e.g., infant metabolic mass screening). In some other instances, there is as yet little evidence to warrant intensive identification efforts in early infancy, either because there is no therapy of proven efficacy or because intervention cannot be successfully undertaken at that age.

Frequently, very early morbid events result in very long-term developmental aberrations which are not clearly discernible during infancy. For example, current intensive newborn care is validated by favorable changes in mortality, considering salvage rates of the extremely low birth-weight infants, and by a lower percentage of severely and profoundly handicapped survivors. However, one-third of those who are thought to have escaped developmental delay are destined to encounter severe learning problems in our schools.

Considering both the structure and the resources of today's health care system, it is evident that the only feasible means of reaching prospective school failure is in dealing with infant and early childhood populations who are known to be at the highest levels of risk of experiencing developmental problems. Such populations include those with known genetic risk, graduates of intensive newborn care, and those detected in mass population screening, in addition to those who survive severe acquired traumatic or infectious illness.

With the probable exception of those whose risk is acquired, these populations are identified in specific service projects in most states, the detection purpose being fulfilled regularly. However, the consequent intervention responsibility is seldom given equal credence and the relationship between detection and direct management remains distant or obscure. Most management strategies undertaken in order to alter developmental outcome fall into the educational domain, yet programmatic continuity with preschool programs rarely amounts to more than unilateral prescriptive direction. It is no longer possible to make a distinction between child health and early childhood education. Perhaps the programmatic breach reflects an historic lack of coordination of health and educational bureaucracies, but recently the State of Florida found a mechanism of insuring avenues to appropriate intervention for early detection programs established by statute.

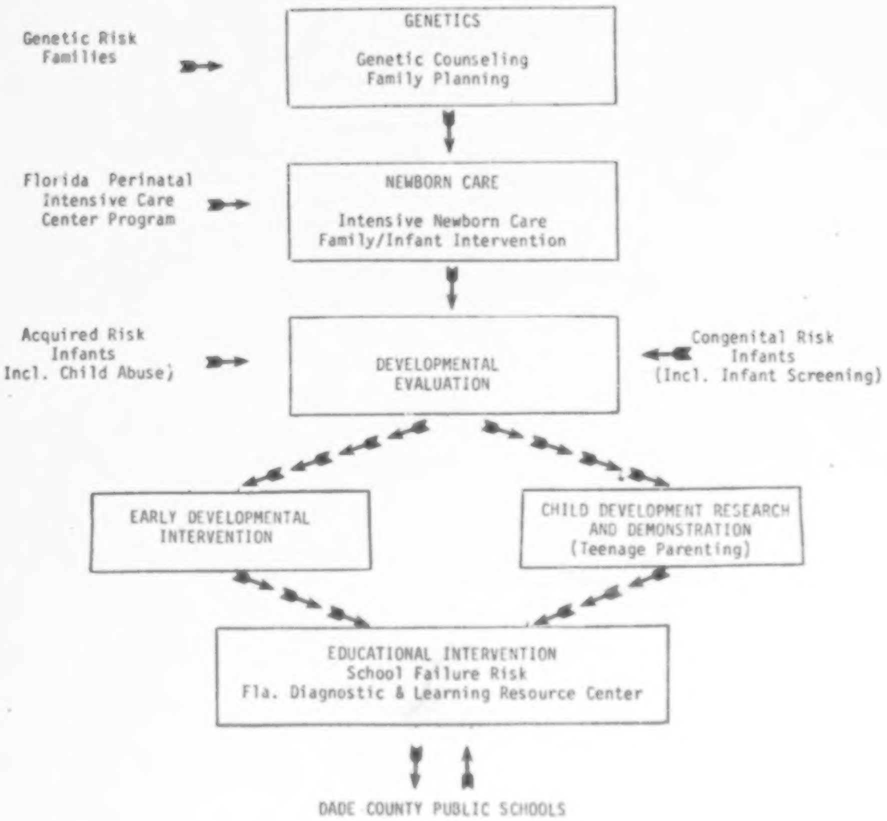
The model being implemented here provides a system of primary and secondary prevention services extending from the regional perinatal and regional genetics programs, through continuous developmental evaluation and into developmental intervention and early childhood educational programs.

UNIVERSITY OF MIAMI

DEPARTMENT OF PEDIATRICS

MAILMAN CENTER FOR CHILD DEVELOPMENT

PREVENTION PROGRAMS


Genetic Risk Families
GENETICS
Genetic Counseling
Family Planning
Florida Perinatal Intensive Care Center Program
NEWBORN CARE
Intensive Newborn Care
Family/Infant Intervention
Acquired Risk Infants Incl. Child Abuse)
DEVELOPMENTAL EVALUATION
Congenital Risk Infants (Incl. Infant Screening)
EARLY DEVELOPMENTAL INTERVENTION
CHILD DEVELOPMENT RESEARCH AND DEMONSTRATION (Teenage Parenting)
EDUCATIONAL INTERVENTION
School Failure Risk
Fla. Diagnostic & Learning Resource Center
DADE COUNTY PUBLIC SCHOOLS

These activities cover diverse specialties as well as interdisciplinary services delivered to approximately 5,000 children and their families through over 15,000 clinic visits, annually. Of these families, greater than 50 percent are Hispanic and the Black population of over 25 percent is growing rapidly due to the influx of Haitian refugees in the Miami area. The University of Miami Perinatal Center is responsible for approximatley 11,000 births annually of which over 1,000 are at high risk.

The Developmental Evaluation Program was originally confined to the longitudinal assessment of infants at high risk graduating from intensive newborn care and has enrolled over 5,000 such children over the past ten years. The Program has undergone progressive expansion through additional state support and is now being applied to other infant populations at developmental risk because of congenital or acquired conditions. This is programmatically and architecturally contiguous with the Center's Developmental Intervention Program functioning at the infant-toddler and preschool levels. In 1983, the Florida Department of Education sponsored a conjointly planned project with the Florida Diagnostic and Learning Resource System of the Bureau of Education of Exceptional Students, linking the Center's early detection and early intervention activities to the public schools. The purpose of the program is to insure collaborative evaluation and prescriptive planning and to provide preservice and inservice traning to special educators and health professionals. Only through partnerships of this type can appropriate management planning be developed for exceptional students, especially as it relates to school problems having their origin in early medical or developmental abnormalities.

Investigative components for which these facilities serve as major resources concern the exploration of technology for the more definitive determination of levels of risk, for a more effective means of examining outcome information and for the investigation of strategies applied in intervention for children and their families.

Prepared Statement of Children's Home Society of Florida, Miami, Fla.

(Submitted by Jean W. Meyers, Executive Director)

The Children's Home Society of Florida is a voluntary non-profit organization established in 1902 which provides a range of services for the benefit of children and families in Florida. The Society, the largest private children's agency in Florida with twelve Division offices located thoughout the State, had responsibility in 1982 for nearly 3,000 homeless, abused, neglected or retarded children and provided services to 1,500 young parents. Children's Home Society is accredited by the Council on Accreditation of Services to Families and Children, Inc. and is a charter member of the Child Welfare League of America, an organization which advocates for children's rights and needed services throughout North America.

The Society's mission is to preserve and strengthen family life. The goal of all the services provided is the best permanent living plan for each child served, preferably with his own family and when this is not possible with an adoptive family or in another appropriate permanent living situation.

It is for this reason that Children's Home Society is supportive of the purpose and activities of the House Select Committee. We congratulate the United States House of Representatives for it farsightedness in establishing the Committee. There is growing recognition throughout the United States of the value of our children and the need to see that their physical, emotional, social, and educational needs are met. The Florida Bar Association under the leadership of Judge Hugh S. Glickstein of the Fourth District Court of Appeal, State of Florida, established in 1983 a Special Committee for the Needs of Children. In a letter to members of the Florida Legislature setting forth the purpose of the Committee, the Judge described children as "our most precious gift and entitled to enjoy the happiness which those adults responsible for them can provide" and further concluded that unless children's needs are met "all the efforts to eliminate crime, poverty, and ignorance are only knee-jerk, bandaid solutions which cure none of society's basic ills."

Our purpose through this hearing is to bring to the attention of the Committee the great need for a range or readily available relevant preventative services for families and children. The Society shares the concern of all responsible organizations, child advocates, volunteers and legislators who decry the number of abused and neglected children who suffer harm at the hands of their parents or other family members and are extremely concerned about the thousands of children drifting in the foster care system without any permanent life plan being made for them. The Society's adoption and group care programs focus on permanency for children and youth in the kinds of living situations just mentioned. These children and families have a right to the priority they command in terms of services and funding for them.

However, only part of America's responsibility for its children is fulfilled by serving these children. The challenge is to strengthen families and to prevent family deterioration which leads to child abuse and placement of children away from their families. The Committee obviously recognizes this need as evidenced by its establishment of a task force for prevention strategies. The task force can highlight this priority need in a nation-wide arena where it will attract the attention of policy makers, legislators, funding bodies, both public and private, child advocates, business and industry. When budgets are tight and social services programs are in jeopardy, the first services to be cut are usually the preventative ones that can avert or at least reduce dependency, delinquency, abuse and neglect. This is due among other reasons to the heavy demand for "survival services" to meet basic human needs and the comparatively few verbal advocates for preventative services whose impact is not always immediately visible.

If preventative services are not available, many families with children will be forced into economic and social dependency and so the cycle of dependency, delinquency, abuse and neglect is perpetuated. Children's Home Society has experience providing preventative social services that demonstrate their cost effectiveness in keeping families intact and in saving taxpayers dollars. For example, the Society's therapeutic homemaker service provided to families with children who are traumatized by physical, emotional and economic problems has a 97 percent success rate in keeping families intact by preventing the removal of children from their parents into the public foster care system. A rural outreach program recently initiated by the Society is providing tangible services such as help with housing, employment and health care needs, and parent training, parent-child play groups and child care in crisis situations via two mobile units that take these services to the clients. A 24 hour toll free telephone service is in operation for the crisis situations. In a six months period several hundred parents, many of whom are isolated from population centers where traditional services are located, have learned that a number of the services they need are available in the community and how to use them.

For years preventative services have been provided by the private sector which has the flexibility and the expertise to plan and to implement them. However, private funds are not enough to carry the vast array of services needed. The combined effort of the private and public sectors is required if prevention services are to continue and expand. The policy on children adopted by the National Governors Association in 1983 is tangible evidence of the concern of the public sector for children and is in fact a commitment to establish and fund preventative family-based services and to improve the health, education, and financial security of families with children.

The Select Committee on Children, Youth and Families is in a unique position to elicit the concerns Americans have about children, to make known solutions proposed and operational that will improve the living conditions of children and their families' capability to care for them, and to advocate for their implementation. There must be services, and this means dollars, available at the "front end" to prevent economic and social dependency or there will be a growing need for dollars at the "dead end" to warehouse broken spirited, economically dependent children and adults in costly institutional programs with little hope of reversing their dependency.

America cares. Now it is time to set in motion the forces that can make caring a reality.

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